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ABSTRACT

This guide, written for therapists and counselors working with eating disordered individuals, focuses on both bulimia and anorexia. A brief historical perspective and comments on epidemiology and etiology are provided. Definitions and clinical characteristics of both disorders are presented as well as psychodevelopmental profiles of male and female anorexia and bulimic clients. The family dynamics associated with the disorders (power structure, individuation, separation and loss, reality perception, and affect) are addressed. Therapeutic techniques for individual, family, and group counseling are presented in detail, exploring initial contact, initial interview, guidelines, ongoing process, and focus. The monograph concludes with a brief look at possible future trends. The appendices include a program for basic nutrition, a listing of eating disorders clinics and programs, and eating disorders associations. (BL)

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FAMINE at the Feast

A Therapist's Guide to Working with the Eating Disordered

H MITZI DOANE

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A THERAPIST'S GUIDE TO WORKING WITH THE EATING DISORDERED

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ABOUT THE AUTHOR

H. Mitzi Doane, Ph.D., is Associate Professor of Psychology at the University of Minnesota, Duluth, and a licensed clinical psychologist in private practice. Her clinical practice focuses primarily on working with the eating disordered and integrates a clinical, developmental and experimental approach. She is an author of several articles on a wide array of developmental and clinical research topics and is a member of several professional associations, including the American Association of Counseling and Development. Dr. Doane holds the honor of being selected as an Outstanding Young Woman of America in 1983, and also being listed in the 1984 edition of *Who's Who Among World Women,* collected by Cambridge University, England.

PREFACE

The eating disorders of bulimia and anorexia have become the plague of the 80s. Descriptions have inundated everything from T.V. specials to Redbook to a recent issue of Ms. Yet we members of the helping professions have been caught with our proverbial pants around our ankles—our literature has been lagging behind the popular media and presenting us mostly with statistics and conflicts.

This is not to deny the validity of statistics or the reality of conflict. The evidence from both suggests our struggle to define the problems and to deal with them. As a clinical psychologist working with the eating disordered, I often feel that I, too, am a victim of this plague. People come to me with problems, questions, and yearnings and I feel like some long-forgotten explorer charting the Mississippi—charting the flow, noting landmarks, and constantly wondering where it ends.

My purpose in this monograph is to provide fellow voyagers my charts, landmarks, wonder and, perhaps, a little despair. I have been working with bulimics and anorexics for four years and have treated well over 100 clients. In the beginning I worked virtually alone, but I do not suggest this route to anyone. Fortunately, today it is no longer necessary.

Famine at the Feast is literally a guidebook, a resource for therapists and counselors working with the eating disordered. It is designed to acquaint you with the basic medical and psychological information pertinent to the area, and to provide a framework within which to undertake individual, group, and family counseling. It will chart rapids, waterfalls, cul-de-sacs and, hopefully, lands-end for you as you course through your own wilderness river.

Nothing in this area can be definitive. Treatment approaches are just too complex to create a cookbook program. I only ask that as you chart your own journey you share your information. Take what you will from this guide, and good journeying!

This work would never have been completed without the support and assistance of Dr. Larry Bright, Dean of the College of Human Service Professions at the University of Minnesota. The monumental task of deciphering my penmanship into legible type was done by Lois Paavola and Marion Fritch.

I want to acknowledge the loving assistance of Martha Doane, Mary Ellen Owens, and Peg Martinez. Words are not enough to thank my co-therapists, Peg Mold and Yvonne Prettner, and our nutritional consultant, Charlotte Juntunen.

I extend to all my clients the wish that their journeys bring them back to themselves. Finally, I want to wish godspeed to Cathy. Bulumia is a fatal disease, and she let it take her life at the age of twenty in November 1983.

H. Mitzi Doane
University of Minnesota

FAMINE AT THE FEAST:
A THERAPIST'S GUIDE TO WORKING WITH THE EATING DISORDERED

This monograph focuses on the eating disorders of bulimia and anorexia. The author presents an overview of both disorders and outlines the physiological ramifications, the medical consequences, and the psychological profiles of this client population. The author also addresses the family dynamics associated with the disorders and provides family, individual, and group therapy techniques. The monograph concludes with a brief look at possible future trends.

Chapter I
WHAT THERAPISTS ARE UP AGAINST

As I mentioned in the preface, I got caught short by the eating disorders of bulimia and anorexia. My clinical training had focused on anorexia as an oddity and bulimia was not even discussed. Unfortunately, my experience was typical. Perhaps we could collect a number of reasons why we were so underprepared, but they are less important than the fact that our inadequate preparation has left us struggling. What is it exactly that we are trying to grasp? Bulimia and anorexia are addictions and, like all addictions, they integrate historical, cultural, physiological, genetic, and social patterns. There are no simple solutions or explanations; we cannot even agree on definitions. Yet, we face "simple" clients--simple in the sense of "ordinary" human beings who seek out their identities and struggle as we all do, who feel, search, grieve, and hope. They are addicted human beings, but they are not freaks, oddities, or weirdos.

My anorexic clients pursue thinness and, as a consequence, they are visible. My bulimic clients try to feed their central emptiness with food, but they can hide their disorder. They hide because of shame and fear, because they hate their dependency on food, but they fear more what life would be like without it.

Although I am not suffering from either bulimia or anorexia, I know what it is to pursue a goal with grim determination. I know the pain of making the goal more important than the process of achieving it. I know what it is to fear becoming fat, what that would mean to my womanhood in America of the 1980s. I know about

binging. I remember when I dealt with my obesity, how I couldn't believe that I would ever be free from the domination of food. I know about using food to fill myself up so that I would be numb to pain or loneliness. I am a great deal like my clients. If you are honest with yourself, you may find that you, too, are more similar than different.

Perhaps you pursued the goals of a career or an ambition with the narrow vision that guides an anorexic. Perhaps you learned to ease your pain or your fear of inadequacy with food, alcohol, drugs, sex, work, sports or whatever. Many of us shied away from working with the eating disordered because the very thought disgusted us.

Cauwels (1983) quotes a psychiatrist about an experience with an anorexic client:

> One of our earliest patients gave the nurses the impression that she was hoarding food, but we never quite caught her at it. One day a most violent stench began to emanate from her room, so the head of the service ordered the nurses to strip the room and search it completely. We found twelve containers of rotting butter, all sorts of rotting vegetables and other foods hidden around the room. It was nauseating for both the doctors and the nurses. We're only human--we felt disgusted by the whole thing. (pp. 31-32)

This psychiatrist is truthful. Many of us do find the eating disorders disgusting, but what we find so repellent may well be how much of ourselves we see in these clients. We cover up our obsessions and compulsions. We disguise them to fit societal norms. And yet, I know how often I hoard what I love, keeping it hidden away. I know how I struggle with my addictions of smoking, of work, of perfection. Am I so different? No. The disgust I need to overcome arises not out of my clients but out of myself. Daily, my clients teach me about the hazards of judging, for if I judge them, I judge myself.

A Brief Historical Perspective

Anorexia nervosa was described by Morton in 1694. Morton's patient was a 20-year-old English woman who had been restricting her food intake and suffering for two years from amenorrhea, weight loss, digestive disorders, and fainting. Morton attempted to treat her with salts, waters, and tinctures, but she continued to lose weight and died after three months of treatment. Morton diagnosed the young

woman as suffering from "nervous consumption" stemming from "sadness and anxious care" (p. 4).

In an excellent article, Casper (1983) outlines a succinct historical view of both eating disorders. She quotes Gull (1873), who grapples to understand anorexia:

> I have endeavored to obtain from the patients some more precise information concerning the sensations they had experienced, and which had induced them to avoid food. None of them have been able to furnish me with anything more exact than what I have reported. The typical formula employed during the course of the disease was reproduced--'I could not; it was too strong for me, and, moreover, I was very well!' (p. 9)

Laseque (1873) struggles with the same enigma:

> What dominates in the mental condition of the hysterical patient is above all, the state of quietude--I might almost say a condition of contentment truly pathological. Not only does she not sigh for recovery, but she is not ill-pleased with her condition, notwithstanding all the unpleasantness it is attended with. (p. 10)

Casper (1983) points out that it was not until the 1940s that clinicians accepted anorexia as a manifestation of an overwhelming desire for thinness and began to search for its psychological and physiological underpinnings. Bulimic behavior, which was often mentioned in the early anorexic literature, was also not studied as a syndrome until the 1940s. Clinicians reacted to the disorder with consternation and puzzlement:

> When we first learned of bulimia, we found it hard to believe for a couple of reasons. So little had been written about bulimia that when we first began to hear of bulimic episodes, we couldn't really reconcile them with the rest of what we knew about anorexia nervosa. Here these girls were starving themselves to emaciation, yet they also described binging, and it just didn't seem consistent. When we began to believe that it happened because we heard about it from so many anorectic patients, we then found the nature of the gorging hard to believe. So much food is eaten--and in a virtual dissociated state in which the woman is almost oblivious to the environment and totally incapable of terminating the binge at a reasonable point.
>
> Yet when we first started to work with bulimic patients, we were probably more confident than we should have been. It was easier for us, in a sense, to relate to this behavior than to anorexia nervosa. Most of us don't starve ourselves, but we do often snack excessively--in front

> of the TV set, at a party, in a restaurant--so we felt binging to be more comprehensible than starving. We thought that all we'd have to do would be to identify what triggers the binges and then explore why the victims have so much trouble ending them. That's a major problem--to approach bulimia too confidently without recognizing how pernicious the symptoms are and how out of control the patient is. (Cauwels, 1983, pp. 32-33)

A Few Words About Epidemiology and Etiology

Whatever the historical roots of the disorders, they are very much with us today. Halmi, Falk and Swartz (1981) report a 13% incidence rate for bulimia in college populations. Pyle, Mitchell, Eckert, Halvorsen, Neuman and Goff (1983) report that 50% of college students binge occasionally; 60% of female students binge. Overall, they predict that 8% of the college population are likely to be bulimic.

I believe these statistics underestimate the problem because the data come from self-reports. Bulimics suffer from shame about their problem and are unlikely to confess it even anonymously. According to Dr. Craig Johnson (quoted by Cauwels, 1983), "A lot more women have bulimia than we think. Not a lot more than we know, a lot more than we think" (p. 58).

The incidence of anorexia is not as high and the rate is lower. It affects approximately one out of every 200 young women between the ages of 12-18 years (Vigersky, 1977).

The majority of sufferers of both disorders are female. Only 5-10% of anorexics are male and Halmi et al. (1981) find that 13% of bulimics are male. Although the male sufferers are receiving a great deal of attention, they do not seem to be so different from their female counterparts (Rouan, Schmit & Duche, 1982).

Bulimia usually develops in late adolescence or early adulthood. It is not uncommon for sufferers to seek help years after its onset, sometimes as many as 15 years later. Anorexia, on the other hand, seems to exhibit a bimodal population--one group in early adolescence around the onset of puberty, and the other in late adolescence and on into the twenties (Vigersky, 1977).

Both disorders, and especially bulimia, occur across classes, although Bruch (1973, 1978) and others originally thought that anorexia was a middle class phenomenon. This classless phenomenon is particularly prominent among college students. The disorders seem to occur primarily among whites, but my preliminary investiga-

tion of the Native American population in northern Minnesota suggests an 8% incidence rate for at-risk women. The disorders also extend beyond national boundaries. The National Association of Anorexia Nervosa and Associated Disorders reports occurrences in Japan, Western Europe, Indonesia, Malaysia, and Central and South America (Cauwels, 1983). In short, the problems are global in both incidence and severity.

A thorough discussion of etiology is beyond the scope of this work, but suffice it to say that we are products of our current high-stress culture. The complications of our times lead to a variety of problems, especially to eating disorders, and I do not believe it is a coincidence that these disorders have recently become more widespread. Readers are referred to Boskind-Lodahl (1976) for a detailed presentation of this issue.

As noted earlier the majority of the eating disordered are female, and in our age it is particularily difficult to be a female. Women are experiencing a greater array of life choices--while careers are the expectation, the traditional roles of wife and mother are still very much with us. We are in the age of superwomen, of women who cook, clean, and bring home the bacon. Our young women must face the new demanding world without benefit of role models or an "old-girls network." It is no wonder so many seek solace in anorexia or bulimia. Anorexia provides a way to seek control of self in a world where control is hard won, and bulimics resort to the solace of food and the control of purging.

Men and women alike are victims of today's emphasis upon seeking the "perfect" body. We live in a culture where food is plentiful, where food abuse is common. Can you think of any holiday which doesn't center around food? At Christmas, we celebrate by gorging for a month straight. On Valentine's Day, young men bestow on their lovely ladies 50,000 chocolate covered calories. When we celebrate births or grieve deaths, we do so with food. And yet, the greatest sin in our culture is to be fat. We can indulge, but we had better not gain. This is a setup which for some results in a no-win situation, and the primary losers are women. An older generation, raised during the depression, would never think of throwing up good food--maybe binging occasionally or hoarding against hard times, but never choosing to starve or gorge and then purge.

My generation understands this much better. We live with Madison Avenue telling us how to look, feel, dress, and be. Our movie idols are svelte, skinny women. The Betty Grables, Dorothy LaMours, and Marilyn Monroes are no longer with us. Instead, we have Jane Fonda, an openly professed recovering bulimic, and the deceased Karen Carpenter. The world becomes increasingly dangerous, especially for people who seek validation outside themselves, and that is precisely what the eating disordered do. They are victims of the culture because they seek affirmation from it. Your job and mine is to turn their focus inward, to help them take back their lives from whomever they have given them to--Madison Avenue, TV, their peers, their lovers, their families. We need to teach our clients and ourselves to live in today, to resist the temptation to look for culprits we can blame, and to acknowledge the responsibility as our own.

A Note About Terms

Anorexia nervosa is the commonly accepted term. You will see both anorectic and anorexic in describing the population. "Anorectic" is primarily British in origin. I use "anorexic" as I find it easier to spell and to say, but for no other reasons; both terms are equally acceptable.

Bulimia is referred to as bulimia, bulimia nervosa, and bulimarexia. Bulimia is the most commonly accepted term. Bulimarexia has been made popular by the team of Boskind-White and White (1983). This term possesses a specific bias. These researchers object to the notion that bulimia is a psychiatric illness. Cauwels (1983) quotes Boskind-White on this issue:

> I don't even want to call it bulimarexia. We believe bulimarexia is a habit. Like cigarette smoking and alcohol abuse, it may be a very serious habit, but it is still a habit. It has been learned, and it can be unlearned. Many of these women learn to gorge and purge by imitation after having heard of someone else doing it. "Illness" implies the whole medical model. These women don't have a psychopathological problem; they're normal, healthy women who want to be skinny, and most of them would be terrified to think that they had a psychiatric illness. Even labeling the habit "bulimarexia" was the least palatable part of our work, because we felt women could use it as a safe edifice, a medical illness to hide behind until they found therapists on whom to shift their own responsibility for binging. (p. 22)

If you see bulimia as a habit, use bulimarexia. If you see it as a dependency or an illness, use bulimia.

Chapter II
DEFINITION AND CLINICAL CHARACTERISTICS: STARVING, BINGING, AND PURGING ARE HAZARDOUS TO YOUR HEALTH

This chapter is designed to clearly define the two disorders and to make special note of their medical implications. Both disorders can kill (Halmi, Brodland, & Regas, 1975) and it is paramount that therapists working in this area know about possible ramifications and complications. Appropriately for our era of holistic approaches to medicine, eating disorders demand attention to the entire person--not to do so might well be lethal.

Bulimia

The term "bulimia" literally means ox-hunger, and the ingestion of large amounts of food is its hallmark. Pyle, Mitchell, and Eckert (1981) define a binge as a rapid ingestion of food in a relatively short period of time where the eating is out of control. Typically, bulimics do not think of eating a sandwich as a binge. Their focus is on the loaf of bread, perhaps on the contents of the refrigerator, or even the contents of a supermarket. They see themselves as a giant mouth gorging its way through a mountain of food and in turn becoming a walking blimp. Mitchell and Pyle (1982) report that in a typical binge bulimics eat an average of 3,000-4,000 calories. The range is even more frightening, as it is between 1,200-15,000 calories per episode!

Binging takes time and lots of it. The median binge lasts about one hour (Mitchell, Pyle, & Eckert, 1981). When my clients seek treatment, they are typically binging 14 times weekly. Thus, at a minimum, they are spending two hours a day maintaining their addictive behavior. That is on a good day--days which are characterized by stress, fatigue, premenstrual symptoms, or uncomfortable feelings usually result in a much higher incidence.

The typical binge foods are usually densely caloric and easily vomited. Mitchell et al. (1981) reports that ice cream is the most popular binge food included in 60% of the binges. In 30% of binges, you will find bread, doughnuts, candy and soft-drinks. Other common foods include cookies, popcorn, milk, cheese, and

cereal. If the bulimic client is particularly concerned about losing weight, she may begin to binge on salads and other "diet" foods.

From this discussion there are three things you need to remember: (1) Binging involves a loss of control, one which is highly similar to that of an alcoholic. (2) Your clients are spending appreciable amounts of time engaging in their behavior and may often have an impaired memory of just what they ate or did. (3) They define their world on the basis of their disorder. In fact, they typically plan their day around binge-purge times and restrict their lives accordingly.

At this point, I want to refer you to Table 1 which contains the Diagnostic and Statistical Manual for Mental Disorders (DSM) (1980) criteria for identifying bulimia.

Table 1

DSM-III Diagnostic Criteria for Bulimia

A. Recurrent episodes of binge-eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:
   (1) Consumption of highly caloric, easily ingested food during a binge.
   (2) Inconspicuous eating during a binge.
   (3) Termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting.
   (4) Repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics and/or diuretics.
   (5) Frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. Depressed mood and self-deprecating thoughts following eating binges.

E. Bulimic episodes are not due to anorexia nervosa or any known physical disorder.

Points A and B(1) have already been considered, and I will now discuss the remaining criteria. B(2): Typically the binging is done in secret. Most bulimics are

horribly ashamed of their loss of control and will do anything to hide it. Often they have eaten normally with family or roommates prior to the binge. However, as the disorder progresses, they find the desire to binge increasingly difficult to control. At this point, they remove themselves entirely from open eating (Russell, 1979).

B(3): Not always does the binge end in purging. In an attempt to stop the purging process, many go to sleep, seek company, etc. They may also engage in ritualistic behaviors to try to bring their eating into control.

B(4): The majority do purge and the method of choice is vomiting. In my client population, 88% use primarily vomiting. This is in line with the 90% reported by Mitchell, Pyle, and Miner (1982). Most bulimics start out by putting their finger down their throat. However, they quickly learn to ingest large amounts of fluids during a binge to make the vomiting process easier, less painful, and more rapid. In addition, many clients abuse laxatives—40% of the clients at the University of Minnesota Clinic, for example. My clients typically experiment with laxatives initially but soon stop, reporting that they feel too sick and tired all the time. With the 3% of my clients who use laxatives as their primary purgative, the typical amount is 30-60 capsules taken as many times per week as they can tolerate. Additionally, clients frequently experiment with diuretics, diet pills, and enemas.

B(5): Bulimia is often a hidden disorder in the sense that bulimics do not appear emaciated. Of the 93 clients I have worked with, 42% are overweight, 48% are at ideal weight, and the remaining 10% are below suggested weight, with only two clients of this group drastically underweight. Weight fluctuations are common as the result of binge-purge/fasting routines. Fairburn (1981) reports that purging is a relatively poor weight control device. This research indicates that 100% of the surveyed individuals gained weight after a year of binging and purging, because the purges are not totally effective and the size of binges often increases over time.

C: Most bulimics, when they seek treatment, are in severe distress over their behavior. They fear losing control in public and many have done just that, but they do not know how to stop. They are in a state of panic.

D: Depression is a crucial issue in bulimia, but it presents the researcher with the chicken-egg quandary. Is the depression a result of the disorder or does depression initiate it? Researchers (Casper, 1983; Eckert, Goldberg, Halmi, Casper, & Davis, 1982; Fairburn & Cooper, 1982; Pope & Hudson, 1982; and Pyle et al., 1981)

purport that bulimia is part of a broad-based depression. Typically, depression is common among the families of bulimics. Regardless of the etiology of the depression, many individuals will binge during a depressed time and the depression will deepen after a binge. Research on the effective use of anti-depressants with bulimics is unclear (Pope & Hudson, 1982) and is still highly controversial. I will discuss the topic of depression more thoroughly in subsequent chapters.

E: Vomiting does not always indicate bulimia. It may also be a conversion-reaction or a reaction to another psychological disorder. It is not uncommon behavior within schizophrenia. There are also cases of vomiting as part of a life-style, for example, among actors before a performance as a highly effective tension-release mechanism. In addition, many athletes regularly use vomiting, fasting, laxatives and diuretics as part of training. Although these techniques may become habitual, they are acceptable behavior within their group and may not indicate psychological dysfunction.

There are also numerous physical malfunctions that may result in binge-eating. These include epilepsy, CNS Tumors, Kluver-Bucy syndromes, Klein-Levin syndrome and lesions within the hypothalamus. Because of the physiological reasons for hyperphagia (increased appetite, leading to overeating), it is good practice to insist your clients get a thorough medical examination.

Medical Implications. Bulimia results in decided physiological changes and clients should be made fully aware of them. Typical complaints include weakness, lethargy, abdominal pain, and irregular menses (Mitchell, Pyle, Eckert, Hatsukami, & Lentz, in press). Other common features include dental caries, perimyolsis (the eating away of tooth enamel), and swelling of the parotid glands (parotidomegaly) which are found between the soft tissue between the ear and the lower jaw.

The parotid glands produce saliva and the enzyme, amylase. The pancreas also produces amylase. Amylase is the enzyme chiefly responsible for breaking down starch for further digestion. In both eating disorders, amylase production seems to be higher than normal. Researchers theorize that parotidomegaly may be due to increased amylase production along with irritation due to the presence of stomach acid. If your clients are experiencing parotid swelling, their cheeks swell and are tender along the lower cheeks near the jawline.

Mitchell and Pyle (1982) hypothesize that parotidomegaly may also be associated with delayed gastric emptying which is evidenced in both disorders. Evidently, the body adjusts to the insults of fasting and vomiting by holding onto food longer in the stomach. The mechanism which accounts for this is not fully understood. However, the result is that the body becomes more efficient at uptaking available calories. For example, a piece of bread has a total of 75 available calories. However, 10-15% of those calories are usually lost during digestion. In the case of active bulimics and anorexics, the body may increase amylase production and delay emptying the stomach contents which results in uptaking almost all the available calories. These two responses are also present in other mammals during times of starvation (Slattery & Potter, 1983).

Therapists can use the information in helping their clients. First, a thorough dental examination is in order. Second, clients may often complain of abdominal pain after eating. The pain is real and may well be the result of delayed gastric emptying and gastric dilation (the swelling of the stomach due to the ingestion of food). Mitchell et al. (1982) report that stomach rupture may even occur in bulimia. For these reasons, clients should eat small, evenly spaced meals throughout the day and this should continue for at least six months until the body resumes normalcy. Parotid swelling may last for up to three months after abstinence from binging and vomiting; swelling after this point may indicate resumed bulimic behavior.

Vomiting and laxative and diuretic use lead to loss of body fluids. This in turn may result in alkalosis and dehydration (Mitchell et al., 1982). The alkalosis may be serious as reduced levels of potassium (rare), sodium (rare), and chloride may result in cardiac arhythmia (irregular heartbeat). Since this is the case, clients should increase water intake and be sure to eat adequate amounts of potassium-rich foods: tomatoes, melons, pineapples, potatoes, bananas, to name a few.

Anorexia

Anorexia nervosa literally means "loss of appetite due to a nervous disorder," which seems simple enough but is grossly distorted. Anorexia may not involve a "loss of appetite" at all; rather, the anorexic may be in constant pain from starvation. A more appropriate definition of anorexia might be: an intense fear of gaining weight and becoming fat that results in self-induced starvation.

The DSM III states that the major criterion for anorexia is at least a 25% weight loss or a body weight of 25% below normal (see Table II). Although anorexia may often be detected long before this criterion is met, such weight loss is the norm rather than the exception (Halmi et al., 1975).

Table II
DSM-III Diagnostic Criteria For Anorexia

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.
B. Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.
C. Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.
D. Refusal to maintain body weight over a minimal normal weight for age and height.
E. No known physical illness that would account for weight loss.

Anorexia is a progressive disorder that starts out innocuously enough. The client goes on a diet. Typically, she is not overweight and intends only to lose a few pounds, but one pound leads to another. If a ten-pound weight loss feels good, how much better will she feel about a 20-pound loss; she is dancing the limbo and seeing how low she can go. It is as if the client becomes addicted to dieting, enamored with the power of her self-control, and gratified by her increasing thinness. Emaciation becomes beauty.

Along with the weight loss, paranoia increases. Friends and family who initially applauded the weight loss now panic, and the client interprets their concern as a conspiracy. "They are trying to make me fat. They are envious of my beauty and my control." The paranoia produces even more determined dieting, and yet the fear of fat increases as she loses weight.

This pervasive fear results in a distorted body image where the client actually sees herself as fat. This is another clear indication of anorexia: although the anorexic sees other bodies for what they are, she sees herself as having hips and thighs and a stomach that are gargantuan. To make matters worse, she typically refuses to see herself as ill and often resists intervention.

Initially anorexics are obsessed with dieting. They refrain from highly caloric foods and systematically eliminate others until they are comfortable eating only a small number of "safe" foods, for example, fruit, vegetables, yogurt, and fish, etc. Many anorexics also abuse laxatives, diuretics, and enemas, and a significant number begin self-induced vomiting. The vomiting may or may not be associated with binging. Many clinicians and researchers suggest that these individuals represent a different type of client and refer to them as anorexic-bulimics to distinguish them from "food-restrictors" (Holmgen, Humble, Norring, Roos, Rosmark, & Sohlberg, 1983; Strober, Salkin, Burrough, & Moore, 1982). I will discuss the psychological differences between the two groups more fully in Chapter III.

Another highly obvious behavior pattern is exercise-abuse. Many clients push themselves to engage in highly strenuous physical activity, even in hospital settings, where they try to pace their calories away. (Yates, Leehey, & Shisslake, 1983, point out the striking similarity in exercise patterns between "obligatory" long-distance runners and anorexics.)

As a consequence of these numerous abuses, several body changes occur. Almost all anorexics lose their menses (amenorrhea) (Frazier, Hall, & Silverman, 1979), and about 40% stop menstruating even before they lose a great deal of weight. No one is sure why, but several investigators believe it may indicate a primary hormonal dysfunction (Fichter, Doerr, Pirke, & Lund, 1982; Richard, Rodier, Bringer, Bellet, & Mirouze, 1982).

The most popular theory to date attempting to explain anorexic amenorrhea is the "critical body-weight hypothesis" (Falk & Halmi, 1982). The evidence suggests that 15% of the total body weight must be fat tissue in order to maintain a menses. This is a biological adaptation possibly to avoid pregnancy during periods of starvation. This does not account, however, for those who become amenorrheic even before drastic weight loss. While researchers must try to understand this puzzle, what is of even greater importance is that many will not resume menstruation after

gaining normal weight. Here again we have no answers, only problems. Although lack of menstruation does not always indicate lack of ovulation, and anorexics may become pregnant, most of them do not. Your client may well be making the terrible choice of permanent sterility (Ghose, 1982; Seidensticker & Tzagournis, 1968).

Physiological Problems. The list of physiological problems associated with anorexia is large. I have listed them in Table III to assist your diagnosis. Where figures are available for percentages, I have included them. The material was taken from Silverman's Anorexia Nervosa (1977).

Table III
Physiological Problems of Anorexia Nervosa

Symptoms	% of Population
Amenorrhea	100%
Constipation	40-100%
Abdominal Pain	20-30%
Cold Intolerance	20%
Hyperkinetiem	20-35%
Lethargy	20%
Low Blood Pressure (90/50)	20-85%
Low Body Core Temperature (34.2-35.9°C)	15-100%
Dry Skin	60%
Lanugo	15-85%
Bradycardia (low resting pulse) (60 pr. minute)	25-90%
Edema (swelling in wrists and ankles)	15-30%
Petechiae (bleeding under the surface of skin)	10%
Parotidomegaly perimyolsis	?
Dental caries	?

Almost all the symptoms are understandable in light of starvation. One that may be unfamiliar is the growth of lanugo hair on the body. This hair is fine, long, almost down-like; most often it will grow on the back and buttocks and is probably the body's way of trying to retain warmth. Scalp hair, on the other hand, becomes sparse and dry, and although the anorexic is worried about its unattractive appearance, she may be protective and even fond of lanugo if it develops. Many stroke it lovingly—an interesting, yet odd badge of honor which I don't pretend to understand.

As mentioned earlier, many anorexics will experience delayed emptying of the stomach contents as a means to make caloric uptake more effective. There is also a risk of gastric dilation or rupture which may be fatal, and therefore the eating must be carefully monitored, with small and frequent meals. Because of this, the host of medical problems, and the recalcitrance of the population, the safest initial placement for an anorexic is usually in the hospital. In later chapters, I will discuss outpatient therapeutic procedures for anorexia. However, it is my experience that advanced anorexics do not respond well or at all to an initial placement in outpatient treatment; they need the structure of an in-hospital treatment program. (Interestingly, bulimics respond better to outpatient treatment but medical supervision should still be required.) Therapists who undertake treatment of an anorexic still in the throes of starvation are as foolhardy as chemical dependency counselors trying to work with active drunks. Starvation induces neurosis (Bruch, 1973, 1978), and many of the psychological characteristics of anorexia due to starvation will ameliorate with weight gain; for example, irritability, anxiety, depression, social withdrawal, a decreased level of concentration, lethargy, insomnia, and obsessionality. Weight gain certainly will not eliminate all these symptoms, but you will not know who you are working with until the nutritional insult is removed.

Therapists and counselors clearly should not work with anorexics who are not under the care of a doctor. There should be absolutely no exceptions to this rule. Moreover, because eating disorders are diseases of the whole person, no one professional has all the answers. We must recognize the limits of our expertise as therapists and expand our interactions with other professionals.

Chapter III

PSYCHODEVELOPMENTAL PROFILE OF ANOREXIC AND BULIMIC CLIENTS: SEEKING IDENTITY, OR YOU ARE WHAT YOU EAT

As I discussed in the preface, dealing with this population is akin to charting an unexplored river. Full of twists, turns, and new insights, the process is occasionally overwhelming and sometimes conflicting. The information I present in this chapter is an attempt to compile not only my observations but those of several others. The charts do not always agree but consensus about the river's flow will be reached only when the river is studied at its extremes of flood and trickle.

In this chapter, I will not discuss the two disorders separately, as there are more similarities than differences. Separating the two might create the illusion of dichotomy, and although dichotomous thinking is a problem with both groups, it is not representative of the problem. The ultimate problem that both face is simply put: it is the result of seeing themselves as never good enough and not knowing how to take the risk of fully loving themselves. It is as if their rivers flow through a desert, a desert of emptiness, loneliness, and despair. The eating disorder is a way of dealing with the isolation; it is a dam to prevent going forward into the wasteland. You, as a therapist, may well have to go into that desert with them or at least describe an alternate route through which to flow.

Few clients will be able to pin-point the start of their disorder. In about 66% of the cases, you will find a likely precipitating stress such as a divorce, a death, an illness, a family tragedy (Eckert, 1982). But it is almost impossible to point to a particular trauma and say unequivocally that is the cause. This is not to minimize life stress but to emphasize that the disorders are typical for the 20th century; they are as complex as our times. I will discuss how to deal with these traumas more fully in subsequent chapters.

Remember that the eating disordered are typically female. I concur with Boskind-Lodahl (1976) who hypothesizes that these are disorders rising out of a woman's place in our culture, a place that is highly dependent. She quotes T. L. Laws, author of The Second X: Sex Role and Social Role, in describing the outcomes of this dependency:

> Social dependence, as a habit of responding, has a number of consequences...First, the reliance on rewards coming from others makes the individual very flexible and adaptable, ready to alter her behavior (or herself) in response to words and threats. Second, she is limited to others as a source of rewards, including self-esteem, for two reasons: (1) the necessity of being accommodating and responsive works against the development of a sense of self which might oppose the demands of others, and (2) any evidence of the development of the self as a source of approval or of alternative directions is punished by others. The "responsiveness" and the sole reliance on social support make the woman extraordinarily vulnerable to rejection (meaning failure). (p. 38)

This gets directly to the heart of the problem. Both anorexics and bulimics suffer from terribly low self-esteem, an almost crippling need for approval from others, and an anxious desire to achieve and receive recognition which culminates in setting unachievably high expectations for themselves. The vast majority are highly perfectionistic and overly compulsive (Eckert et al., 1982). They are trying to achieve not only the perfect body but the perfect "everything." They focus on grades, sports achievements, social acceptance, to name a few. Obsessed is the only word adequate to describe their quest for perfection, and whatever they do or accomplish is not enough. Their thinking focuses on "what I should have done" or "what I am going to do." They dance the tarantella, viciously pursuing more, faster, better until they give up in defeat, die, or emotionally collapse.

You would think that such low self-esteem would indicate a terrible sense of inferiority, but, surprisingly, that is not the case. These individuals are highly narcissistic and have a tremendous need to feel superior to others. They constantly compare themselves to others and when they feel they are better than someone else in almost anything, their egos swell. They become internal peacocks strutting and puffing with self-pride.

A typical comment I make in group therapy is, "Who died and left you queen?" This confrontation is often shattering because in making such a statement, I break a paramount rule. I make public their narcissism. Not only do they have an inordinate desire to feel superior, but the superiority must always be secretive. They hide their narcissism behind a facade of inferiority and typically deprecate themselves with such remarks as, "I'm so fat, I'm so stupid, I'm so lazy." No one must ever know that they search almost everyone looking for vulnerabilities and foibles. They are

searching for ways to feel better than others, but they don't want this known because it would destroy their "nice little girl" cover.

These people raise impression management to a high art. Their need for approval and their social dependency result in desperate attempts to please others. As Silverman (1977) states about anorexia and is equally true of bulimia:

> Typically, the mother of an anorectic girl will say, "This child was always so good, a perfect kid. Of all my kids, this was the one I never thought would give any trouble!" Well, these weren't just good children; they were almost pathologically good, almost psychopathologically compliant. (p. 148)

I see this compliance as a form of almost pathological lying. As I explain to my clients, there are two predominant ways of lying, either by commission or by omission. Lying by commission is the telling of an outright fib. Usually this is done to avoid blame or to impress others with our personal uniqueness or grandiosity. Lying by omission is far more subtle but just as much a lie. It involves not telling the whole truth, editing our comments to protect our feelings or those of others. Lying by omission helps the client to be whoever the other person wants her to be. Therapists need to be aware of both types of lying--clients will often exaggerate their progress and try to be what they think the therapist wants. Don't be sucked in. You are as easily impression-managed as anyone else. Beware of quick cures and progress that is full of sweetness and light.

The need to please others not only sets the client up to lie but may also result in social withdrawal. Imagine going to a party with the desire to be liked, admired, and approved of by everyone. How many masks will you have to wear and what happens if the group is not homogeneous? Who do you please? How do you avoid having your phoniness discovered? As a consequence of the masking, most clients will retreat socially and limit social participation to small, highly similar groups or to individuals.

Another typical pattern, especially for bulimics, is to be more extroverted and outgoing. They hide their phoniness by a cover of gregariousness. Usually, they possess highly developed social skills, express themselves in an articulate manner and yet fear intimacy just as much as the anorexic.

This fear of intimacy has not only resulted from fear of discovery of their plastic facade, but may be related to fear of sexual intimacy as well. In the early literature, there was a great deal of theorizing concerning the sexual nature of the disorders, especially anorexia.

Explanations, as proposed by Waller, Kaufman, and Deutsch (1940), were common:

> We see, then, a syndrome the main symptoms of which represent an elaboration and acting out in the somatic sphere of a specific type of fantasy. The wish to be impregnated through the mouth, which results at times in compulsive eating and at other times in guilt and consequent rejection of food, the constipation symbolizing the child in the abdomen and the amenorrhea as direct psychological repercussion of pregnancy fantasies. (p.14)

Ten years later we find Nemiah (1950) stating:

> We have so far considered the mouth, eating and the gastrointestinal tract from the point of view of its role in the function of nutrition. However, not only were disturbances found in the more sexual function of the mouth, but alimentation was associated with various unusual fears and attitudes. Six patients found kissing flat, distasteful, disgusting or irritating. (p. 241)

These explanations are a bit too psychoanalytic for my taste and yet problems with sexual intimacy are common. Most anorexics have little or no sexual experience and they fear sexual involvement. Bulimics tend to be more eclectic. My clients seem to fall into three distinct categories: those who, like the anorexics, avoid sexual contact; those who are highly promiscuous; and those who do not seem to be sexually dysfunctional and yet, like many of us, do not feel totally comfortable with their sexuality.

My position is that fear of intimacy is more a developmental phenomenon than a sexual problem. How is one to be comfortable in engaging in a highly physical, intimate behavior when one is suffering from low self-esteem, a dislike of her body, and an inadequate sense of self, hence identity? These problems do not make comfortable bed fellows.

Sexual issues need to be addressed by therapists, especially in light of my findings of the high incidence of incest and rape or near-rape experiences among my

bulimic clients (Doane, 1983a). I find that 39% of my clients are victims of incest, which is defined as sexual behavior with a child or adolescent by a family member, family friend, or trusted individual such as a neighbor. The incidence of rape among my clients is 32%. My figures are at odds with those of Eckert (1982) who reports a much lower incidence rate. My belief is that the difference lies in the way information is obtained, based on my experience with the sharing of complete sexual histories as part of our group therapy program. I will discuss that more in the sections on interviewing and therapeutic techniques.

My clients are dichotomous or dualistic thinkers. They constantly categorize themselves and their experiences as good or bad, right or wrong, and black or white. There is no middle ground. They are people who are extreme in almost everything. They are either on or off, up or down. This dualism sets them up to be highly judgmental of themselves and others. Interestingly, they don't often perceive themselves as judgmental of others, but rather they see others as the judges and thus see themselves as persecuted victims. Regardless of their age, they exhibit the typical adolescent egocentric thinking patterns. They believe everyone is constantly looking at them and finding fault. Roommates and family members don't understand; they condemn. Walking down the street, they perceive themselves as the center of attention. And it is no wonder that they think that way; it is a classic case of projection: they accuse others of doing exactly what they themselves do.

Given the dualism, the projection, and the extremes, it is clear why so many of them are anxious. Anxiety pervades their lives, and the eating disorder provides a way to cope with anxiety. For the bulimic, food is a mood-altering drug. It sedates; it fills up; it relieves tension; it diverts attention. For the food-restricting anorexic, food is almost an object of worship. Many think constantly of food (a typical behavior with anyone undergoing starvation). They may cook for others and many are avid food pushers. It is not uncommon for anorexics to fatten up anyone they live with.

In both these cases, we are dealing with an addiction. The bulimic is addicted to the binge, addicted to the time it takes, addicted to the feeling of wild abandon. As one of my clients so succinctly described it, "It is easier to feel full than it is to be fulfilled." The bulimic is also addicted to the tension release of vomiting, to the sense of purposiveness and control she gets out of vomiting. "Yes, I binged but I took

care of my pigging out by vomiting. I know how to handle my excess." Similarly, the anorexic is addicted to her perceived sense of power or control over food. She is also addicted to the attention she receives and to her feeling of "specialness."

Whether restricter or binger, there is addiction and dependency. The patterns of food dependencies are no different from those of chemical dependency. You will see denial and minimizing. Food is a drug used to shut out the world out there; it is used to alter or stop feelings; it is used for solace and for self-punishment.

Even the disorders take on a specialness. They provide a way to define themselves, a way to identify who they are. So many of my clients are thoroughly pleased when labeled anorexic or bulimic. It is as if they finally have a sense of who they are. They are no longer Mary Sunshine or Janey Dark; they are bulimic or anorexic. Many will go around and literally tell everyone they meet, "See, I'm special, I'm bulimic." Being enamored of the label can also be a dangerous dependency. It becomes a scapegoat. It becomes an excuse. It is as if within the client's heart there exists a chamber labeled anorexia or bulimia. No matter what problem or difficulty presents itself, the client is likely to open that chamber and blame the problem on her disorder. "My dad doesn't understand my bulimia. That is why he doesn't have time for me." "My roommates can't understand my anorexia." "I failed the test because I binged last night." The examples go on and on. The therapist's job is to confront this nonsense head on, and it's not an easy process--no one likes to give up scapegoating.

Not only is food abuse addictive, but many clients are also chemically dependent. Goff (1982) reports that one out of every six bulimics is also chemically dependent. The bulimia is usually the older addiction and will typically worsen during or shortly after treatment if it is not addressed during the process.

The most common chemical dependency is alcoholism. It makes sense that alcohol is the drug of choice (although speed and downers are also quite popular). Alcohol use raises ambient blood sugar levels after a purge. This eliminates the dragged out feeling often associated with hypoglycemia. Alcohol minimizes stress and anxiety, which are typical bulimic problem areas, and the haze shrouds the person's feelings of insecurity and inadequacy. Alcohol abuse also provides a good cover for vomiting at parties. "So what that Mary is vomiting. Why shouldn't she? She drank all that beer." What goes unnoticed is all the chips and dip that Mary ate as well.

The younger adolescent anorexic is not typically chemically dependent. The mere questioning about drug use may send her into a tailspin. How dare you accuse her of doing something that despicable? She is a nice little girl and she is a snob. She even resists the analogy of chemical dependency with anorexia. You must be crazy to think she might be addicted--she isn't that kind of person. The later onset anorexic is much more likely to be chemically dependent and the incidence is only slightly less than that for bulimia.

What does this mean for you as a therapist? It means that you will often be dealing with a double addiction. Hopefully, the eating disorder will be addressed during chemical treatment. But unfortunately, treatment centers may not be aware of the problem, may choose to ignore it, or may feel that their program is ill-equipped to handle "food" issues. As a consequence, you will likely find yourself working with a client whose eating disorder has spun out of control after treatment. Whatever you do, don't try to work with a bulimic or anorexic who is still actively using drugs.

A history of chemical dependency often makes your job as a counselor easier. Your client will have a deeper understanding of her own addictive processes if she has gone through treatment. Use the analogy for all it's worth because the patterns will be the same.

I am a developmental psychologist by training. I always begin working with a client by asking myself, "Where is the client functioning developmentally?" Once I know this, it becomes much easier to ask, "Where does she need to go?" My experience with both eating disorders is that the client is dealing with adolescent issues whether she is 15 or 59. Of course, the hallmark issue is "Who am I?" The following discussion focuses on this search for identity and is borrowed from a work of mine (Doane, in press).

Since Erikson (1968a, 1968b) first postulated the "identity crisis," many theorists have modified his notions. One of the most intriguing expansions has been presented by Marcia (1966, 1976), who hypothesized that young people (typically in late adolescence or young adulthood) have more than two ways of dealing with the identity crisis. Remembering that Erikson postulated that an adolescent, when faced with a crisis, reaches either ego identity or diffusion, Marcia proposed that there were two alternate outcomes based on his notion of identity status. In this model (See Figure 1), the establishment of identity occurs as a function of at least two

Figure 1

IDENTITY STATUS DEVELOPMENT

	Crisis	No Crisis
Commitment to Issues	Identity Achievement	Foreclosure
No Commitment to Issues	Moratorium (or Identity Diffuse)	Identity Diffuse

Note: From "Development and Validation of Ego-identity Status" by J. Marcia, Journal of Personality and Social Psychology, 1966, 3, 551-558. Copyright 1966 by the American Psychological Association. Reprinted by permission.

dimensions: the existence of a crisis and the degree of commitment to key issues. These issues are religion, morality, politics, occupation, sex roles, and self-concept (Marcia, 1966). The existence or non-existence of a crisis, when combined with commitment or lack of it to the above issues, results in four outcomes or identity statuses.

Young people labeled "identity achieving," when faced with a crisis, grapple with their own stand on the issues. They seek to discern parental influences, to evaluate what fits for themselves, and then to make a decision based on their own beliefs.

Foreclosed individuals have circumvented the crisis associated with identity acquisition. They do so by co-opting and totally accepting their parents or any significant others' stands on the issues. Outwardly, foreclosed young persons seem ideologically committed and highly motivated, whether in pursuit of careers or their beliefs about ethical or moral values. However, they lack a true identity. It is as if they wrapped themselves in the cloak of another, thereby avoiding conflict. Both identity achievers and foreclosed young adults are highly verbal and able to express their opinions and are not readily distinguishable from one another.

On the other hand, those in the state of moratorium or identity diffusion are adrift and unable to make decisions. The moratorium individuals face crisis after crisis, but instead of dealing with them, they put the crisis in abeyance. They want to know who they are, but they are unable to make any decisions at the point of crisis. They are highly intense young people, but confused. It is not a permanent state: it is simply an avoidance procedure, a running away until the time seems right.

Diffuse individuals may or may not be in crisis. In either case, they do not seem to be concerned about who they are. If they are in crisis, they don't care: "That's just the way life is." They seem to observe themselves, somewhat disinterestedly; they ask few questions. Colloquially, I label these individuals "floaters," who are carried by a stream where all decisions are not only a function of the current in which they find themselves, but also out of their control or ken.

It must be remembered that Marcia (1966) did not envision these labels as typologies. As Erikson (1968a, 1968b) recognized, they are states and states are not

stable. They are seen as an ever-changing process. People may move in or out of any one of these and may evidence several aspects simultaneously.

One may then ask, if the states are so unstable, how can they be useful? Additionally, how might the model provide a counselor with clues to understanding the mechanisms of the bulimic or anorexic? They do so by providing a frame of reference. By giving counselors a place to start, the model enables us to see the problem as if captured in a still photograph. The danger for practitioners, however, is to forget that the still photo is also part of a moving picture.

Where, then, does the food-abusing client fit? "Anywhere" is my first response and probably the most true; however, I think that typically you will find the young food-abuser in the foreclosed category. While working with this population, over and over again I saw intense young women, highly moral, highly motivated, and propelled by an overwhelming desire to be validated, to be approved of, to be accepted. The little perfect "princess" as described by Bruch (1973) is a most appropos analogy. They appear so desirous of parental approval and peer validation that they lose themselves in the identities of others. Given that these individuals have foreclosed upon themselves and their quest of who they are, the counseling process will often entail identity seeking.

Male Bulimics and Anorexics

Up to this point I have said nothing about males who suffer from eating disorders because it is not a typically male problem. Males are about 10% of the anorexic population and even less are bulimic (Cauwels, 1983). Their numbers have been so few it is difficult to make generalizations, and those generalizations that exist have been tentative and speculative.

My expertise is limited. I have worked with three male anorexics and two male bulimics. Suffice it to say that males are highly similar to the females in pattern. However, they are usually appreciably sicker. Most typically you will see a definite, precipitating traumatic event such as a death or divorce. Treat them as you do your female clients. Don't highlight their "specialness." It is their belief in their uniqueness which has kept them sick. Don't feed that problem. Don't isolate them. If you run a therapy or support group, they belong in it. And don't bend over backwards trying to make them feel comfortable or fit in. Their problem does not arise out of their penis, but out of their humanness.

Chapter IV
THERAPEUTIC TECHNIQUES FOR INDIVIDUALS

In this chapter, I will address the therapeutic work of other clinicians. However, most of both this chapter and the one on group therapy is my own work. I will address what has worked for my co-therapists and me and, perhaps equally important, what has not worked. The data I will share are my own and are based on at least a six-month follow up. Where it was possible to follow clients further, that is also reported.

To date, I have worked with 131 clients: 29 were primarily anorexic; 14 were anorexic-bulimic; and the remaining 88 were bulimic. My expertise is largely biased toward bulimia.

What I do with my clients works and, as I become more knowledgeable in the area, client remission rate increases. I refer to remission rate because I believe that eating disorders, like any addiction, are not cured. It will be an issue your clients may well struggle with for the rest of their lives. I concur with what Dr. Shervert Frazier (Frazier et al., 1979) has said about anorexia, and in many ways it is just as applicable to bulimia:

> We don't use the word 'cure' in treating anorexia nervosa. Once the patient has recovered from the major symptomatology that doesn't mean she is well. The symptoms are only an external manifestation of an internal biochemical, hormonal, and pyschological disorder. (p. 148)

What then is the prognosis for the disorders? Figures are more readily available for anorexia since the disorder has been researched longer. The Eating Disorders Clinic at the University of Minnesota Hospital reports the following prognostic data (Eckert, 1982). They estimate that from 2% to 20% of anorexics will die from the disorder, usually due to starvation or electrolyte imbalance; about 1% of the clients will commit suicide. (Suicidal thoughts are common among this group, although few will actually attempt it; then again, their disorder is already a way of committing suicide.) Approximately 50% of the clinic clients fully recover, i.e., regain a normal weight and normal eating habits. Another 25% will improve, but

they still will have a pronounced weight problem and/or poor eating habits. The remaining 25% will remain chronic anorexics, resistant to any intervention. It is out of this group that mortality is high.

As I mentioned earlier, 13-50% will remain amenorrheic. Additionally, over half the clients will still suffer from psychological problems such as kleptomania, weight obsession, drug abuse, and social withdrawal. The University of Minnesota Clinic reports that 90% of their clients are employed after treatment even when they are severely debilitated. This may not be surprising because they are classic obsessive-compulsives. However, about one-half continue to have problems in their interpersonal relationships (Eckert, 1982).

The data reported above are corroborated by other clinics and researchers and, indeed, can be considered typical (Agras & Kraemer, 1982; Hsu, Crisp & Harding, 1979; Theander, 1970). The diagnosticians are also in agreement about the most prominent outcome indicators. Those which indicate a good prognosis are as follows: (1) the younger the client is when the disorder begins; (2) the less weight she has lost; (3) the shorter time she has had the illness; and (4) the less use of purging. It is clear that early diagnosis is crucial, and perhaps the recent media coverage has opened the eyes of parents, physicians, and educators.

The data about the prognosis of bulimia are more scarce and yet not as alarming. Pyle (personal communication, 1983) reports that 80% of the clients are binge-free after going through a well-designed and intensive outpatient treatment program. Unfortunately, most of us do not find ourselves close to a major treatment center such as the University of Minnesota (Minneapolis) or Michael Reese Hospitals (Chicago). However, our limited program in Duluth is almost as successful. In the program I run, which is a combination of individual and group therapy and adjunctive support groups, 74% of our clients are still binge-purge free at a three-month follow up. The percentages drop to 69% and 63% after six months and one year, respectively. For those clients who enter family therapy, the percentages are even higher: 89% at three months; 82% at six months; and 79% at one year. Family therapy has a decided impact. However, since many of my clients are college students living a far distance from home, family therapy is not even an option.

I must warn you about the above data. These figures are based solely on self-reports. Where possible, I interview the former clients, but the majority of reporting

is done by mail. There is a distinct possibility that clients are lying by omission. Fortunately, Duluth is a small city and secrets are hard kept here.

On then to a discussion of therapy. Where do you begin? At the beginning, of course, and your two most important tools are your initial contact and your initial interview.

Initial Contact

I speak to most of my clients first over the phone. The eating disordered experience a great deal of shame about their problem, and most will want the security of a phone for their first reaching out for help. Whether you see or talk to them first, don't scare them. They are easily spooked. Keep the contact brief and light. If they are experiencing panic, calm them and confirm that you hear them.

I'll typically say to a bulimic individual, "I don't care if you continue to binge and vomit until I see you. I'm not going to ask you to stop now. So go ahead and do it if you need to." In many cases, I find that giving the client permission often results in their stopping—that we are dealing with an adolescent, regardless of chronological age. Use that information for all it's worth. I also want my clients to assume charge of their own healing, and I must beware of exerting too much power or control. If I am dealing with an individual struggling to define herself, what is the value in my telling her what to do? There is a more appropriate time for guidance once trust and rapport exist.

Initial Interview

Handling the initial session requires far more structure, especially for the therapist. You must find out who and what you are dealing with and proceed accordingly. I assume most people reading this are well-versed in the dynamics of interviewing. What I offer now is a guide to the information you will need.

My first piece of advice is <u>not</u> to focus immediately on the eating disorder. Start out with the basics: name, address, age, etc. Get the person comfortable with answering questions. Then focus on her social history: Where is she living, with whom; is she dating; where is she working; what are her favorite activities, perhaps even social goals. But beware of this last item—she may be in a state of turmoil, and asking about goals may exacerbate that and lead to self-deprecation.

Next, do a thorough inventory of her eating patterns and history. Table IV provides a listing of pertinent questions.

Table IV
Eating History and Patterns

1. What are your present weight and height?
2. What has been your lowest adult weight?
3. What has been your highest adult weight?
4. When did each occur? What was going on in your life at the time?
5. What is your "dieting" history? Have you ever gone to a special program like Weight Watchers, TOPS, or a commercial weight loss clinic? What was the outcome of such a program?
6. When you "diet," what do you do? What happens to you emotionally and physically when you diet?
7. When you are not dieting, what is your eating pattern like?
8. Can you remember the time when your eating disorder began?
   a. If so, what was going on in your life?
   b. For example, how were you feeling about your body?
   c. What was your work (school) life like?
   d. What was going on in your family?
   e. What was your social life like?
9. What is your eating like now?
   a. How many meals do you eat a day? When do you eat them?
   b. How much do you eat at one time?
   c. Are you a fast or slow eater?
   d. Where do you eat and with whom?
   e. Who does your cooking?
   f. Do you binge? (Define binge for the client.)
   g. If so, how often and what do you usually eat?
   h. Have you noticed a pattern to your binging; i.e. are there times, places, or situations where you are more likely to binge?

i. What kind of feelings do you experience before, during, and after a binge?

j. Have you noticed certain things which trigger a desire to binge for you?

k. Do you ever fast or go on a really low calorie diet?

l. How often do you do this? What is it like for you? How long does a fast or diet last for you?

m. What usually gets you to start such a program?

10. Do you make yourself vomit?
    a. If so, how do you do it?
    b. Do you vomit after a binge?
    c. Do you ever induce vomiting when you haven't binged? If so, when?
    d. Does anyone know you vomit?
    e. If so what has been the reaction?
    f. How often do you vomit?
    g. How much time do you spend eating and vomiting per day?
    h. Do you experience any physical problems from your vomiting, such as sore throat, swollen glands, bad breath, hoarseness, bleeding, sore mouth?
    i. Do you ever experience having vomitus in your mouth while you are eating, i.e. starting to vomit when you hadn't planned to?
11. Do you ever chew your food and then spit it out without swallowing it? (See following text for explanation.)
12. Are you constipated a lot?
    a. Do you use laxatives?
    b. If so, what kind, how many, and how often?
    c. What happens to you physically when you use laxatives?
    d. Have you ever experienced explosive diarrhea or having diarrhea in public?
13. What, if any, prescription drugs are you taking?
    a. Do you ever use diet pills?
    b. Do you ever use diuretics (water pills)?
    c. Have you ever used amphetamines?
14. How much and what kinds of exercise do you do daily?

a. Do you ever exercise after you have eaten?

b. Are there times when you just have to exercise because you are full of energy? (Here you are looking for hyperactivity.)

15. How do you feel about your body right now?

a. What weight would you like to be at?

b. How strongly do you want to be at that weight?

c. Have you been at that weight in the past? If so, how did you feel about yourself then?

d. How often do you weigh yourself?

16. How old were you when your period started?

a. Are you taking birth control pills?

b. Are you regular now? If not, tell me how you see the pattern of your period changing within the last year or so?

17. How much do you think about food and when you are going to eat next?

a. How often do you talk about food and eating with other people?

b. How much do you think about your weight? Do you talk about your weight with others? If so, with whom do you talk?

c. Are you ever envious of the figures of other people? Who?

d. Is there anybody in your family with a weight problem? If so, do you worry about having the same problem?

e. Do you ever diet with other people and if so, who? (Here you are looking for a pattern of competition.)

f. Has anybody ever mocked or teased you about your weight? How do you feel about what they said? How do you feel about them?

g. Do you constantly think about the calories you've eaten?

h. How much do you cook? Who do you cook for?

18. Do you ever experience mood swings, i.e., where you are up and then you find yourself down?

a. How tense are you?

b. When you are under a lot of pressure, how do you try to take care of your stress?

c. Do you ever find yourself snappy or irritable? Who are you likely to be irritable around?

d. What do you do when you get angry? Are there people you find it easier to get angry with? How do you feel when other people are angry with you? What do you do when this happens?

e. Do you ever get depressed? What happens to you when you are depressed? How long does a typical depression last?

f. Have you ever thought about committing suicide? What do you think about when you do?

19. Do you ever steal food from people?

a. If so, who do you steal from?

b. Have you ever shoplifted? If so, what did you steal and what were the circumstances?

c. Have you ever stolen anything besides food from someone? Who? When?

20. Are you having problems with your sleeping, either sleeping too much or too little?

a. Do you eat at night, especially late at night?

b. If you can't get to sleep, what do you do?

21. Tell me about your social life.

a. What is your dating history?

b. Are you currently dating anyone now?

c. Do you get out and socialize much?

d. How often do you go to parties?

22. How much alcohol do you use?

a. Is there a pattern to your drinking?

b. How often do you get "drunk," and what are you like when you do?

c. Do you ever vomit after drinking?

d. Do you ever drink after vomiting?

e. Do you ever drink instead of eating?

f. Is there anyone in your family who drinks? Does any one of them have a drinking problem?

g. Do you smoke? How much? When did you start? Has your smoking increased lately? Do you ever smoke instead of eat?

h. Do you use other drugs, such as marijuana, cocaine, tranquilizers etc? If so, tell me about your use.

i. Do you drink caffeinated beverages such as coffee, diet soda, etc? How much do you drink?

23. If you see yourself as having a problem with your eating, what do you think is keeping you doing it?

a. Do you ever use your problem to relieve tension or try to relax?

b. Do you ever use it to try to stop gaining weight?

c. Do you ever use it to try to cope with uncomfortable feelings like anger, hurt, loss, feeling inadequate? If so, which ones and what is a typical situation for each?

d. Do you want to stop being bulimic or anorexic? Why?

e. What got you to come see me?

24. Have you ever been touched in a way you didn't like?

The last question needs some explanation. As I mentioned earlier, there is a high incidence of sexual assault among the bulimic population especially. Few clients respond with the truth when asked if they have been a victim of incest or rape. This question takes the client off guard, and it is a question few women can answer negatively. The question is crucial--even though your clients may not tell the truth initially, you have asked the question. It sits and simmers and will not go away until it is dealt with.

Although the listing in Table IV is extensive, it is not exhaustive. It only begins to scratch the surface of the problem. However, after completing it, both you and your client will know a great deal, not only about the presenting problem, but about who the individual is. And yet you have far more to do.

There is one question that still needs explanation. There are bulimic individuals who chew their food and then spit it out. I have one client who did this exclusively and never used any other purging technique. Although the exclusive use of chewing and spitting is rare, many bulimics will do that on occasion. The issue needs to be addressed because many of them rationalize that this isn't really a problem. Although it is not as serious as inducing vomiting, this behavior can get out of hand and needs to be brought under control.

Next, it is important to check out the medical history and the physical symptoms that may be present, particularly: fatigue, bloating, gas, diarrhea or constipation, edema, swollen cheeks (parotid glands), palpitations, dental and mouth problems, poor concentration, hair loss, stomach pain, dry skin, cold intolerance. After checking these I usually describe in detail the physical consequences of the disorders. I tell the client that this is not a scare tactic but information that she needs to be aware of. I usually insist upon a complete physical examination. If you are working in a health service, this is usually not a problem. If you are not, you may want to make a referral at this point. As you well know, some physicians are more adept and comfortable at working with this type of problem. If you don't have a physician that you feel comfortable working with, beat the bushes until you find one. The best therapy utilizes a team approach. In this case, a physician is a crucial member of that team. I believe in this so strongly that I will refuse to continue to work with a client who refuses to see a physician. I also urge them to have a complete dental examination. They will usually not balk at this one. Remember, most of them are really concerned about their looks and disfigured teeth are the last thing they want.

Individual Therapy Techniques for Bulimics

Once I have completed the initial interview, I find that subsequent sessions need to be highly structured. Much of my work closely parallels the work of Fairburn (1981), Ferguson (1976), and Rimm and Masters (1979). All three researchers/clinicians are highly behavioral, and behavior change is the primary treatment goal. Set out clearly for your clients that the major target of the initial sessions is to interrupt their binge-purge cycles and ultimately to reach complete and lasting abstinence. I liken the initial stages of individual therapy to chemical detoxification. I also assure clients that once they are binge-purge free, then, and only then, will underlying issues be examined.

So many of my clients say to me, "Why do I do this? My bulimia is destroying my life. How did I ever get into this mess in the first place?" My typical response is, "Do you know why Duluth is cold?" They look at me quizzically and say almost bitingly, "What has that to do with anything?" I reply, "Just answer my question. Do you know why Duluth is cold?" In their typical people-pleasing fashion, they give me

a host of answers. Then I say, "O.K. Does knowing about our latitude, the chill of Lake Superior, or the Canadian wind currents enable you to do one thing about making Duluth warmer?" "No, of course not," they reply. "All right, my guess is the same holds true for you and your bulimia. I could give you a number of reasons why you do it and so could you. Right now, however, knowing why probably isn't as important as knowing what, where, when, and how. The why's you may not be able to change now. The others you have control over. Are you game to taking control of your life?"

So first and foremost, stress for your clients what the end result of treatment will be, i.e., taking back their lives. They are going to learn to put food back in its place, a place of celebration, not fear and imprisonment, a place in which they acknowledge daily: "When I eat, I choose life. I choose to celebrate me. I choose to honor myself and I do so by eating, not by gorging."

How do you guide your clients to this place of celebration? What they need most is information. I go over the definition of bulimia, its medical and psychological symptoms and outcomes, and I typically provide reading material. An excellent book for them to read is Cauwels' Bulimia: The Binge-Purge Compulsion (1983).

Then, both of us need data. To this end, I require that the client keep a journal monitoring her binges and purges. The rules are highly explicit: (1) Record every time you get the urge to binge. Pay particular attention to where you are, who you are with, what time it is, what feelings you are experiencing, and what went on just prior to the onset of the binge. (2) Write all this information down before you proceed to binge. Make no exceptions. You are in charge of your healing. I am not asking you not to binge. I am asking you simply to interrupt the sequence of your urge and put that interruption into behavior. (3) Write in your journal, "I choose to binge" or "I choose not to binge." I want the client to be aware of the choice and therefore of the control she has. Too often, she convinces herself that she has no choice. This is simply not the case, and she needs to start being aware of how she abdicates her responsibility. (4) Follow the same sequence whenever you feel the desire to purge. (5) Write in your journal, "I choose to vomit" or "I choose to keep what I ate." Whatever word the client finds repulsive in describing her purging--e.g., puke, vomit, throw up--is the word she should use both in the journal and in therapy. Beware of allowing her to use euphemisms such as "I made myself sick" or "I had an upset stomach."

I cannot overemphasize the importance of the journal. As Rimm and Masters (1979) point out, the only way to change a behavior is to know what is controlling it. The journal provides both you and the client the necessary knowledge of the antecedent stimulus events that trigger the behavior. These antecedent events fall into four major categories: situational, social, emotional, and cognitive.

For trigger situations, have your client look for particular locations where food is abused such as the kitchen, parent's home, car, school, work, restaurants, stores, bakeries. Also have her look for particular times of the day. The majority of my clients binge in the late afternoon or early evening. This is often due to skipping breakfast or lunch, and it is also a convenient alone time.

In the social category, have the client analyze whether her binging is associated with particular people. Usually, certain people such as roommates are the triggers. Also make her aware of what she does with food in social situations such as parties. Explore with her how binging or the fear of it may result in becoming more socially withdrawn or isolated as a way to avoid the embarrassment of lack of control.

Feelings are also important to binging. All of us experience eating to relieve boredom, ease tension, release anger. Many times I tear into a sandwich instead of a person with whom I am upset. Eating has a calming effect--my co-therapist calls this "numbing out." Have your client examine how she "numbs out" when she binges, and how she uses eating as a release. As one of my clients so aptly states, "I eat because I am full. Full of rage, hurt, loneliness, or whatever and I want so desperately to be empty of feelings. I even eat when I'm too happy. It seems that, if I let myself feel anything, I might spin out of control. And then who would I be?"

The cognitive category is the most complex. Here, you want your client to be aware of her self-talk--what is she saying to herself that sets her up to binge and vomit? This category includes such self-deprecating talk as, "I'm a fat slob" or "I'm a failure." She also needs to be aware of rationalizations: "I ate too much today already, so I will go ahead and pig out and then I'll throw up"; or "I deserve to do this. I'm so uptight and I'll get it out of my system and then I'll start fresh in the morning."

Your client needs to be aware of the two-edged nature of the disorder. It is a release, but also a sword of self-punishment; it rescues, but it also victimizes. It is both cure and disease.

Expect resistance to the journal-keeping. Very quickly, most of your clients realize how the very act of writing not only interrupts the behavior but also stops it. Many find any excuse in the book to avoid doing it. Confront your client on this and insist that you will not continue to work with her if she doesn't keep the journal. As I say, "If you are not willing to change, why are you coming to see me? I can't do this for you. That's your job."

The next therapeutic step is to have your client examine the positive and negative consequences of the bulimic behavior. An example of a positive outcome is the belief that she can eat whatever she likes without weight gain. (Of course, you will have shown her otherwise.) Other positive outcomes include relief from tension and boredom and the security of swallowing feelings, such as anger, and then vomiting them up. The negative consequences are legion. They include guilt, shame, the financial burden, ill-health, lack of concentration, social isolation, fear of discovery, inefficiency, poor work performance, and even legal problems for shoplifting. Have the client work up her own list, monitor the actual cost to herself in both time and money, and weigh these consequences against the pitifully few positive outcomes. This, in and of itself, won't stop the behavior, but it begins to put the bulimia into a larger perspective. Bulimics have a tendency to minimize and rationalize their behavior by focusing on individual bulimic incidents instead of the larger costs over time.

Once the client and I get a handle on her particular pattern, then intervention begins in earnest. I follow a five-fold plan whose end result is placing the client in group therapy (which I will discuss in a later chapter). In fact, as in detoxification programs, my co-therapists and I do not allow anyone in the group who is not abstinent or, as we say, "clean." The five-fold intervention includes: structuring a nutritional program, altering antecedent events, utilizing a cognitive-behavioral approach, manipulating consequences, and eliciting support from family and friends.

Nutritional Intervention. I do not attempt to guide the nutritional program alone. I enlist the aid of a registered dietician with whom I work jointly, but separately. Once I define the parameters of the program to the client, I send her to the nutritionist. My job is to monitor behavior and deal with feelings; the nutritionist monitors food records, meal plans, and intake. I strongly urge you to do the same. Although I am well-versed in nutrition, I am not an expert. Utilizing outside

expertise allows me to concentrate on what I do well and also provide clients with a complete program.

I insist that my clients eat at least three meals a day and that breakfast is crucial. Many of them panic when I tell them this. I handle the panic by giving them information about the hypothalamus.

The hypothalamus is a central brain structure. You can approximate its location by drawing imaginary lines between your eyes and your ears. The place where they intersect is about where it is found. It is extremely close to the pituitary, the master gland of your body, and the two work in conjunction. The hypothalamus controls and influences a variety of body functions such as temperature, sleep, sexual arousal, secondary sex characteristics, water balance, and food intake. The hypothalamus is a master integrater connecting emotional and hormonal responses with bodily sensations.

The hypothalamus monitors the ambient blood sugar levels. When the blood sugar level drops, it triggers our appetites. When the blood sugar level rises, it triggers the sensation of satiety or fullness. Researchers find that starvation, fasting, and dieting often interfere with the normal functioning of the satiety center within the hypothalamus. This results in the appetite not being turned off when blood sugar levels rise. It is as if the body is so alarmed by the nutritional insult that it "demands" binging. For this reason, bulimics need to eat adequate amounts and at regularly spaced intervals. Not doing so may result in a binge initiated by the body's own physiology. Eating three meals a day drastically reduces the incidence of binging.

If your client is uncomfortable with eating three meals a day because she feels it's too much, your nutritionist can design a program of mini-meals throughout the day. Many of our clients eat six times daily. In any case, counsel your client never to go longer than four to six hours during the day without eating.

For an adequate assessment of what is eaten and when, your client must keep thorough food records in addition to the journal. It is important that she weigh and measure the food and record the intake when she eats. This allows the nutritionist to thoroughly assess nutritional intake and adjust it where necessary. She also helps the client plan menus each week. In the beginning, she asks her to list the "unsafe" foods on which she is likely to binge and removes these foods from the initial meal plans.

Typically, these foods are high in sugar or fat and their absence doesn't put the client in nutritional jeopardy. The nutritionist also designs alternative food sources where possible. After the client's eating has stabilized, the nutritionist slowly begins to reintroduce the "banned" foods so that the client can learn to control them.

Since many of our clients are obsessed with counting calories, we utilize a nutritional program which does not require calorie counting. We use a modified, diabetic meal-exchange plan. Space does not permit me to go into detail about the meal exchange system, but literature on it is widely available if you are without the benefit of a nutritionist. Basically, it divides food into six categories: dairy, vegetables, fruits, breads and other starches, protein, and fat. We provide our clients with lists of foods in each category. Then the nutritionist plans a meal prescription for each client that deals with amounts to be eaten from each category, not calories. She adjusts the calorie intake to the individual needs of the client. We usually insist that clients stabilize their weight for at least a month. If they want to lose weight, they can do so gradually (no more than two pounds per week) after they are familiar and comfortable with the exchange system.

A typical prescription for breakfast might be one fruit, one dairy, one protein, and two breads. The client goes to the list of foods in each category and selects accordingly. For example, she chooses to eat half a banana (one fruit exchange), eight ounces of skim milk (one dairy exchange), one egg (one protein exchange) and two pieces of dry toast (two bread exchanges). See Appendix I for the handout we use describing basic nutrition on the exchange plan.

A note is in order here about weighing. I discourage my bulimic clients from weighing more than once per week. I advise that they get rid of any scale they have in their homes and to weigh themselves only at my office or at the nutritionist's. I do this because my clients are obsessed with weighing. The numbers take precedence over any other indication. I want them to get in touch with their bodies, by being aware of how their clothes fit, for example.

It is well known that our bodies react to nutritional change initially with water retention. This, in turn, may result in weight gain but it is only temporary. It is the body's way of maintaining balance. Often clients panic after going on the exchange system because of weight gain, and the panic may result in purging. Explain the phenomenon to your clients and insist that they stay with the program for at least two weeks before they abandon it.

Altering Antecedent Events. An underlying principle of behavior therapy is that behavior patterns are often elicited by stimulus events. The next step is to examine these antecedent stimuli and change them where possible. This is where the journal is of paramount importance because it enables the client to see the relationship between what she does and what else is going on. Ferguson's work, Habits Not Diets (1976), is an invaluable tool for focusing on the habitual aspects of binging.

Below I provide ten general rules that have aided my clients' recovery. These rules are loose adaptations from Ferguson and target several common antecdent events.

Ten Steps Toward Freedom

1. Limit the amount of time spent in the kitchen. Do not socialize there.
2. Eliminate "binge" and "junk" foods from the home. Foods which you may abuse, such as bread, need to be kept out of sight.
3. Always eat at a table in a kitchen or dining area. Do not eat anywhere else in your home, even for snacks. Never eat standing up.
4. When you arrive home, avoid the kitchen. Go and do something else like brushing your teeth, talking to someone, listening to music.
5. When you eat a meal, always set the table, the fancier the better. Remember that you are choosing life. Make it a celebration.
6. Do not read, watch T.V., talk on the phone, or other distracting things while you are eating. Concentrate on that. Savor your food.
7. Many find it helpful to say grace before a meal. Whether you choose to do so or not, spend a little time centering yourself. Be aware of who you are and why are are eating.
8. Eat slowly. You may find it helpful to put your fork down between bites.
9. If you feel full, stop for a while. The food isn't going anywhere.
10. Learn to leave something on your plate. You do not have to lick the platter clean.

I often counsel my clients to eat with other people as much as possible. The social atmosphere often constrains binging. However, be sure the client does not eat around people she associates with binging, e.g. party buddies. Other advice includes complete avoidance of alcohol and marijuana, whose use often results in binging. If clients are particularly likely to associate certain stores or restaurants with binging, these, too, need to be avoided.

We also counsel reducing the intake of diet soda, sugarless gum, and caffeine. Diet soda is high in sodium and often causes bloating and edema. Additionally, many clients use diet soda as an aid in purging. Suggest they limit their intake to no more than three cans daily. I suggest my clients drink water with a dash of lemon. The increased water intake along with the mild diuretic of the lemon reduces edema, if it is present.

Many clients chew gum incessantly. Of course, most choose sugarless gum due to the misnomer that it is calorie-free. It isn't. It has only two to three fewer calories per stick than regular gum. The sweetening agent is usually sorbitol or similar substances. Excess amounts of these sweeteners can cause bloating and diarrhea. Advise your clients to limit their intake to one pack daily.

I also advise limiting caffeine intake. Many of them abuse caffeine-based drinks such as coffee, Tab, and Diet Coke. I find that clients who limit their intake to two to three cups of coffee per day or two cans of Tab feel far more relaxed. Coffee especially can cause increased stomach acid production. If your clients suffer from gastric distress, caffeine irritates the problem.

Many clients use eating as a way of controlling feelings or easing stress. Focus first on other behaviors they can engage in that will accomplish the same result but exclude binging. My suggestions for stress include taking a walk, taking a bath, calling someone, massaging their bodies, painting their nails, saying a prayer. Your clients need to work up their own list, focusing especially on what they find pleasure in doing.

I find teaching relaxation and meditation techniques highly successful. You are dealing with people who do not know how to unwind and they need to learn. I use guided meditation techniques that start with complete body relaxation, as in Jacobsen (1964). Typically, I use music as a background device; Pachelbel's "Kanon in D" and Paul Horn's "Inside" are particularly relaxing. I mention appropriate music

because I suggest the client use such music at home when practicing the relaxation exercises. It then becomes a controlling stimulus and seems to increase their use of relaxation techniques.

When the client is completely relaxed, I use a desensitization technique. I present her with a variety of situations which are antecedent stimuli for the binging behavior. For example:

> Ann, now that you are completely and totally relaxed, warm, and comfortable, I want you to imagine that you are in a grocery store. It is a store that you know well. See yourself selecting a cart and pushing it down the first aisle. You are not hungry. You are not in a hurry. You are in control. Scan the aisle for items that are found on your exchange lists.
>
> Begin to select some safe foods. Feel yourself. You are warm, relaxed, and comfortable as you place those foods in your cart. You know that these foods sustain your life. They celebrate you. Revel in their color, their smell, their texture.
>
> As you move through the store, you begin to notice foods that you have abused in the past. (Here include one or two items you know your client has abused.) Go up to the doughnuts (for example). Look at them. Allow yourself to pick up the package. As you do so, remember that you are warm and relaxed. Know, as you look at the doughnuts, that you have abused this food. Remember losing control with doughnuts. Remember having to vomit doughnuts. Is that what you want to do?
>
> Remember that you are warm, relaxed, and in control. Ann, place the doughnuts back on the shelf and know that you do not need them to survive. They do not celebrate you. Feel yourself smile as you put them back on the shelf. Feel yourself becoming lighter and more relaxed as you push your cart away from the doughnuts.
>
> Know that you are in control and celebrate you. Know that you choose the food. The food does not choose you. Know that and be proud and comforted.

The above example covers only one particular situation. Utilize the information you have about your client's antecedent stimulus situations and do exercises like the above often. Insist that your client take the responsibility to practice at home, and have her report the successes to you. As for failures, listen to them, but teach your client about how she may have sabotaged herself, about how she argues for her limitations. It is not the technique that doesn't work; it is she who isn't working.

To help deal with feelings that the client finds uncomfortable, again I turn to writing or taping as an outlet. I advise her to write down or tape what she is experiencing, and we then discuss it during therapy. If a client prefers not to write, I counsel her to seek someone or someplace in which she feels secure and to go there to compose herself.

Utilizing Cognitive-Behavioral Techniques. Most therapists are familiar with Ellis' rational-emotive therapy (Ellis, 1975; Ellis & Harper, 1971). Ellis asserts that much emotional distress is caused by irrational ideas or negative self-talk. I believe that such irrational thoughts play a role in bulimia. Common irrational ideas among clients are that everyone must like them, approve of them, validate them. They believe that their past experiences will always influence their present and future. For example, "My dad didn't love me. Why should any other man?" The list could go on and on; focus on what your clients say and seek their underlying beliefs. Their irrationality becomes obvious.

When you discover such thoughts or negative self-talk, have them practice replacing the ideas with more positive ones. When clients are miserable about overeating, for example, I focus on how overeating is decidedly different from binging. I ask them to focus on how far they have come, rather than on how far they have to go.

Woolfolk and Richardson (1978), expanding on Ellis' work, provide a distillation of the most commonly utilized irrational ideas. These notions keep us all stuck in a quagmire of negativism. The list, provided below, is highly applicable to both anorexics and bulimics.

1. Believing (superstitiously) that worry helps prevent future mistakes or bad fortune.

2. Evaluating ourselves as failures because we fall short on some standard of performance or expectation of others.

3. Believing that we are inferior or disadvantaged which makes it difficult or impossible for us to lead satisfying lives.

4. Having a competitive, win-lose orientation that makes living into a series of contests and puts our self-esteem on the line in every situation.

5. Engaging in moralistic thinking about how others should behave that leads to frequent feelings of frustration, anger, and moral indignation.

6. Believing that life should be free of discomfort so that we have a low tolerance for life's inevitable frustrations.

No one can avoid pain. And would we want to? As a friend once told me, "Pain is everyone's privilege." We learn and grow from pain. Most of our discomfort comes not from our pain, but our resistance to it. Your clients need to learn that their attitudes about themselves and the world color all their experiences. It is their outlandish expectations of themselves and others that get them into trouble. These expectations set them up to binge and then they rage at the world through their vomiting.

So often clients say to me, "My parents expect too much of me." "My friends and family look down on me." While these may, indeed, be true, I often discover it is they who have the expectations and judgments, not others. They are so uncomfortable with who they are that they project those ideas onto others. They set other people up to be the villains, while they are the innocent victims. That way they can blame. And oh, do they love to blame.

This pattern needs to be confronted and changed. You can accomplish this by using cognitive restructuring. Schmidt (1976) defines this as "any therapeutic technique that employs the change of 'self-thoughts' in order to alter emotional reactions and behaviors toward more favorable outcomes" (p. 72). Such techniques might include teaching clients to contradict self-abusive thoughts. When a client starts thinking, "I need to binge," teach her to yell internally, "Stop it! I don't need to binge." Have her follow through by asking herself what she does need and give it to herself.

Another technique is "countering," where you confirm the "germ of truth" in the client's thought but oppose the exaggerated negativism. For example: Your client says, "I'll never be able to eat like a normal person." You rephrase it this way, "Right now, you are having difficulty. But that is not forever. Look how far you've come. You didn't become bulimic overnight and you won't get better overnight. All you need is practice."

You must teach your clients not to be "Little Mary Sunshines" but reality-based men and women. Life is never black and white, it is mostly somewhere in between. They need guidance in seeing the gray, in seeing the positive within the negative. As I teach them, feelings are like rainbows. In a rainbow no one color ever occurs alone. Some may be brighter than others or clearer, but rainbows are never all green. Feelings are like that, too. In the midst of our deepest sorrow, there is usually some relief. In relief, there may well be sorrow.

Many of your clients make catastrophes out of everything. I call it "creating sanddevils." As you may know, sanddevils are small puffs of dust that rise with the wind from the desert floor. Sanddevils have the potential to become terrible sandstorms but most never do. My clients create sanddevils almost continually. Anything that isn't exactly right is seen as a potential, threatening sandstorm.

I see this thinking as satisfying a need for something to worry about, to focus upon. I also recognize this sanddeviling as a major source of stress in their lives. First, I point out their "catastrophizing" and acknowledge that, indeed, their problem may well become serious. Then, borrowing from Sparks (1981), I ask the following: What's the worst possible thing that could happen in this situation? What's the probability that terrible consequences will occur? Would it really be so unbearable if that event occurred? Have you handled situtions like this in the past and survived them okay?

By focusing on the worst possible outcome, many of my clients realize that if it happened, they would still get through it. Moreover, as we practice, they begin to understand that sandstorms are rare and that they create sanddevils in order to avoid looking at problems within themselves. By continually focusing outside themselves and villifying the world, they do not have to acknowledge how they villify themselves. By examining this process, you help your clients alter their negative self-images and, as a consequence, perceive the world as a safer place in which to live and risk.

Another helpful cognitive-behaviorial technique is "imaging." Teach your clients to use both positive and negative imagery. Let's imagine that you have a client who binges on ice cream. Have her imagine that when she opens the container, it is literally alive with maggots. Have her utilize as many senses as possible. Focus on the putrid smell; the faint, squishing sound of the masses of maggots; the acrid taste that the smell elicits; the slight vibration of the squirming bodies. Negative imagery like this is highly successful. However, I limit my use of it because it can generalize too easily, and I don't want my clients afraid to eat. Its use is appropriate for high-incidence binge foods when those foods are not necessary to good nutrition.

I much prefer the use of positive imagery. It operates out of affirmation rather than fear or disgust. Let's imagine that your client has been invited to a party, one she would really like to go to, but she is afraid. She is afraid of losing control, of binging in public, of needing to vomit. Have her imagine going to the party. Have her repeat to herself: "I can do this. I am in control." Have her imagine walking right by the goodies, smiling inwardly. Put her focus on how good she feels about being there with her friends and being in control. Have her visualize herself as laughing and having a good time without needing to binge. Have her focus on the positive outcomes of going to the party. Again, utilize as many senses as possible--positive imaging works, if it is practiced.

Manipulating Consequences. Abstinence needs to be rewarded. To accomplish this, I use a variety of strategems:

1. Have your client scrape together as much money as she can. Work out a repayment schedule; i.e., give her a portion of the money back for remaining abstinent. Space the pay-offs through several sessions.
2. Have your client draw up a contract governing the above. If she breaks the contract, she does not receive any repayment until she fulfills the agreement.
3. If your client is poor or unable to get together a sum large enough to be rewarding, have her bring to you a number of highly prized, personal belongings. Such items usually include jewelry, sentimental possessions, valued clothing.

4. Have the client draw up a contract governing what she needs to do to get each item back. Always start with her most valued items first.
5. Have her work up a list of things she enjoys doing. Have her reward herself for daily abstinence with at least one behavior from the list. Have her keep a brief, daily log of achievements and how she rewarded herself.
6. Avoid the use of punishment, by either client or counselor, as a behavior modifier. Self-punishment usually leads to depression and self-deprecating anger.
7. It is my belief that people need to make an investment in their own healing. If you are in private practice, always set a fee for your services. When a client is poor, I ask her to come up with an amount that would hurt to pay, but one that doesn't cripple. Remind her of how much money she spends keeping herself in binge-foods. I find that paying for therapy is a highly successful motivator.

Eliciting the Support of Family and Friends. Your clients need the support of people who care about them. But they do not need people who either police or enable their bulimic behavior. I request my clients to invite their friends, roommates, and family members to come to therapy with them. (The next chapter focuses on family therapy.) It is not my experience that friends or roommates need to be in therapy, but they do need information and guidelines.

Many times misguided friends go to extremes trying to deal with their bulimic friends. They watch hawkishly what they eat. They make comments about their food choices or the quantity they eat. They go barging into the bathroom when they suspect the person is vomiting. They throw out or hide the laxatives, diet pills, binge foods, etc. While all of this is well-intentioned, the result of such "parenting" is usually disastrous. Faced with this type of behavior, my clients start becoming sneakers. They binge or vomit more just to spite others. If their anger gets out of control, they either explode or retreat.

At the other extreme are "friends" and roommates who enable. They say such things as, "Come on, let's go get a pizza," or "One cookie won't hurt." Some do this with intended malice, but most are trying to make their friends feel better, to get them out of the dumps, or to calm them down.

What, then, should roommates and friends do? First, they need information about bulimia. After giving them this, I ask my clients to draw up a list of ways that friends can help. Below are some general guidelines I give to roommates, friends, and family.

1. Remove "binge" foods from the house.
2. If your friends are unwilling to do so, then label the food with their name and put the food out of sight.
3. Allow your friends to be in charge of their own eating. Do not interfere, spy, or parent.
4. Try not to socialize around food or alcohol. Come up with other activities that you can do together.
5. Be available. Listen to your friends. Don't minimize their pain. Listening is perhaps one of the best ways to show caring. However, don't let yourself get dumped on. If your friends talk incessantly about their problems, say something like this: "I care and yet I am tired of you always being so negative. I will not listen to that anymore. Tell me what you need and I'll see if I can give it to you. I can't convince you that you are okay or that everything is going to be all right. I can only ask you to tell me how I can help."
6. Don't go on about your weight or your diet around your friends. This is like putting salt in a wound.
7. Don't allow your friends to steal from you. If they eat your food and then throw it up, they are stealing. Confront them on this and demand compensation.
8. If you share a bathroom, let them know you object to the odor of vomit and the condition of the toilet. Ask them either to clean up their mess or to vomit somewhere else. Be insistent on this one. They do not need to screw up your life, too.
9. If your friends frequently ask you about their weight or how they look, say to them, "What do you think? It is how you feel about yourself that is important, not what I think."
10. If your friends continue to binge and purge, expect them to be moody. They have a right to their moods, just as you do. But don't let them dump

on you. Confront them on their irritability, their anger, their depression. Ask them not to be around you when they can't be sociable. You aren't a doormat; you are their friend.

Individual Therapy Techniques for Anorexics

Much of what I have presented for bulimics is applicable to anorexics. That is, their program also uses a five-fold approach. Instead of repeating myself, I will focus in this section on what to do differently with anorexics.

Let me say again, if your client's weight is 15-25% below normal, put her in the hospital. You cannot provide the massive nutritional intervention that is required. As I mentioned earlier, many of her psychological and behavioral problems are a direct result of poor nutrition. It is a futile task to attempt therapy with someone who is starving. Additionally, many anorexics are highly resistant to therapy, and the hospital is the place in which to overcome that resistance.

Fortunately, there are several major treatment programs around the country. (There is a list provided for you in Appendix II.) Many of these centers may be far from you and almost all have long waiting lists. In spite of these problems, I suggest you refer your client to one.

I am fortunate to have a good working relationship with a psychiatrist in Duluth. Often, if I have a client who is unable to get into a treatment program in Minneapolis, I place the client in a mental health unit in a local hospital. I work conjointly with the psychiatrist in designing a program for the client. Usually, this is only a temporary measure until space becomes available in a treatment center.

If you follow the above route, here are some suggestions:

1. If you believe the need is great, insist your client go into the hospital. Low weight, severe depression, self-mutilation, suicidal tendencies, and ill-health are all indications of the need for hospitalization.
2. If your client resists going into the hospital, refuse to work with her. This sounds extremely harsh, but treating an advanced anorexic on an outpatient basis might prove fatal. Do you want the responsibility?
3. Initially, I place anorexics in an open unit. If she eats the prescribed food and does not vomit, she can stay there. If not, I have her moved to a closed unit and work her way out of it by following her program.

4. Have her take part in all the group and individual therapy sessions provided in the unit. She may resist, insisting that she isn't like the other people there. Don't budge on this. She is not unique and she needs to take part in the sessions.
5. Make rewards contingent not only on weight gain, but on the amount eaten, meal size, participation in group activities. Typical rewards include visitors, T.V., or phone calls; some researchers use physical activity as a reward. This is okay as long as it is closely monitored--remember, anorexics abuse exercise.
6. Do not reward complaining. Ignore it. The client usually nags about how bad the food is, how fat she feels, etc. Extinguish such behavior.
7. Typically, an anorexic client will do better eating several times a day. Advise the nutritionist to present more food than is needed at each meal; this often results in the client eating m[illegible]

The process of recovery from anorexi[illegible] (Palmer, 1980) and involves [illegible], and psychological intervention. A[illegible]rapist, you can be most helpful when the client's weight stabilizes, because she needs [illegible]sive and extended after-care.

The nutritional focus needs to be weight gain or weight stabilization. For an anorexic, who is less than 15% below ideal weight, I insist that we set a goal weight. Once this goal weight is set, we then make a contract for the weekly weight gain, which I suggest should be no more than one pound per week. (Remember that here I am not talking about clients who are severely underweight.) Since many anorexics are terrified of weight gain, of becoming "fat," weight gain needs to be slow and gradual.

If your client is pumping herself full of fluid before weighing-in, don't panic. You will discover this after a week or two. Remember that her weight gains need to be cumulative. If you find that she does not maintain her weight, confront her with your concerns about the manipulation. Also be wary of her wearing heavy clothes, and always have her remove her shoes. Often, I request that she weigh-in at the nutritionist's office, who then informs me of the weight. This way the client has to weigh only once a week, for example. It also frees our sessions to deal with other issues. I counsel an anorexic not to weigh at home and to get rid of her scales.

Once your client has reached goal weight, then a weight stabilization program needs to begin. Here is where a nutritionist is invaluable. It is a tricky process to design a maintenance program, and the client needs intensive monitoring.

I require that an anorexic client keep food records, go on the exchange system, and do weekly meal planning. Typically, she does better eating more frequently than three times a day. It is often helpful to eat with your client. By doing so, you can deal directly with any feelings she is experiencing. It also reintroduces her to social eating; she is even more uncomfortable with public eating than a bulimic client.

For anorexic-bulimics, follow the same procedures described previously to control vomiting. In this population, the bulimic behavior typically surpasses food restriction as a problem.

Moderate depression is common among anorexics (Eckert et al., 1982) as well as their family members (Winokur, March, & Mendels, 1980). Increased depressive symptoms are more likely with low body weight, a greater disturbance in body image, a greater use of purging, abnormal eating patterns and attitudes, and greater denial of the anorexia. Anti-depressants, such as Elavil, seem to be somewhat effective in moderating depressive symptoms (Eckert et al., 1982). Lithium-carbonate also evidences effectiveness (Gross, Ebert, Faden, Goldberg, Nee, & Kaye, 1981). The research results utilizing monoamine-oxidase inhibitors appears promising, even in the depression seen within bulimia (Walsh, Stewart, Wright, Harrison, Roose, & Glassman, 1982). If your client continues to experience difficulty with depression, it is in the best interest of both of you to investigate psychochemical therapy.

A feature of anorexia is a disturbance in body image (Bruch, 1962; Meermann & Fichter, 1982). Yet even here, the literature is alive with dispute (Button, Fransella, & Slade, 1977; Garner & Garfinkel, 1981; Garner, Garfinkel, & Moldofsky, 1978). Klesges (1983) finds that female college students are more apt to see themselves as heavier than they are. Interestingly, he reports that overweight men and women underestimate their degree of obesity. His data suggests that women strive for an ideal body frame. If they are overweight, they underestimate their weight. If they are at normal weight or underweight, they overestimate their weight. Therefore, anorexics who see themselves as heavier than they really are are engaging in a common behavior pattern.

In addition, the Klesges' study did not find that over- or underweight female college students saw themselves as less attractive, less likable, or less likely to date. Anorexics, however, have a negative self-image which results in their experiencing all three of these characteristics.

If your client evidences a disturbance in body image, work on addressing it in both group and individual therapy. Useful techniques include: comparisons of before and after pictures, videotaping, eliciting feedback from group members, the use of movable calipers, and whole body outlining. Whatever you do, be patient. Don't berate or try to convince her; just keep providing a reality base.

Eliminate "fat" talk from clients' vocabulary. Instead of talking about gaining weight, use the words "getting healthy." We do not refer to the exchange system as a diet; it is a meal plan.

To assist clients in dealing with negative self-image, focus on improving their social skills. Two important areas are social communication and assertion. I use role playing and modeling in dealing with improving their skills in these areas. After they become comfortable with me in terms of role playing, etc., then these activities can be important components within a group setting.

The poor self-concept often arises out of their inadequate expression of certain feelings. Many anorexics experience problems in even acknowledging anger, much less recognizing it. Additionally, they are inept at asking for what they need. In both cases, they fear rejection. Facilitate their recognition of their feelings by having them keep a journal. This enables them to begin to label and deal with their feelings.

Give them concrete behavioral assignments to practice. One I find particularly helpful is to practice taking praise. So often when someone gives them a compliment such as, "My what a pretty dress you're wearing," they start a litany of self-deprecation. "Oh, it is old." "It makes me look fat." "I got it on sale." Have them learn to say "Thank you" and nothing else. Illustrate for them that when they minimize the praise people give them, they in fact minimize the people. Learning to accept praise graciously not only increases the likelihood that they will be praised, but also results in their becoming more comfortable with and appreciative of themselves.

Poor stress management is a common problem with my clients. I use Kicking Your Stress Habits (1981) by Tubesing as a vehicle to work on stress. This well-written paperback is a step-by-step guide to stress management. It has a workbook format and is appropriate for both individual and group work. It emphasizes time management, affective problems that result in stress, assertion, and even the spiritual components of stress.

Concomitant with stress, anorexics are usually bereft of pleasurable activities. Their lives focus on food. They reward themselves with food. Food is the center of their lives. Many hoard food, cook a great deal, and fantasize about food. They need to learn other self-rewarding behaviors. They need to acquire hobbies and relaxing outlets. Work on expanding their repertoire of pleasurable activities and get them to practice them.

One final comment. Many anorexics are highly dependent upon their families and even boy- and girlfriends. This dependency is akin to an addiction. I cannot overemphasize the importance of working with family and friends. The next chapter focuses on this very issue.

Chapter V
THE FAMILY DYNAMICS

To attempt to understand individuals outside of their families is akin to trying to understand the workings of the heart by examining only one chamber. Our eating patterns develop within a family context, and that context needs to be explored. Beware of laying blame as you work with the families of your clients. Too often in trying to grapple with etiology, we rush to point a finger at mom, dad, or baby sister. A family is an organism. Can we say that the mitochondria within a cell are the most crucial element? Can we say that even of the nucleus? Of course not. No one part is all-important. Families, like cells, are whole organisms and, also like cells, they malfunction. Even if you discover the malfunctioning unit, remember the disorder affects all members. Etiology is complex and not easily pinpointed.

This chapter does not purport to instruct you in the techniques of family therapy. Its aim is to alert you to the "typical" family dynamics of the eating disordered. It also provides some therapeutic directions for you to pursue.

Lewis, Beavers, Gossett, and Phillips (1976) state that a family serves as a matrix of identity for each of us. Internally, families provide both a sense of protection and a sense of belonging. Externally, families transmit to each of us a sense of culture. In accomplishing the job of acculturating us to the world outside, families teach us about our separateness, our humanness, and our independence. Lewis et al. (1976) propose that our sense of identity arises out of the interplay between belonging to our families and belonging to the world. Identity develops out of seeking balance, the balance between belonging and autonomy. It is no easy task. And if you remember my discussion in Chapter III, the seeking of identity is a major issue with the eating disordered population. To understand your clients and their struggle, you must seek to understand where they come from.

In the book, No Single Thread: Psychological Health in Family Systems Lewis et al. (1976) present five parameters on which to assess the well-being of families. These are: power structure, degree of individuation, acceptance of separation and loss, perception of reality, and affect. Let me briefly define these for you and then focus on what my experience and that of others has been with the families of the eating disordered.

Power Structure

Within healthy families, power is shared. Children are empowered as they mature. Power is not dumped on them; rather the amount of power is matched with their developmental abilities. Early on children are taught to choose, and their choices are not minimized. Parents are in control, but not always in charge. In two-parent families, one parent is not more powerful than the other.

In belonging to such a family, the individual experiences a sense of completeness. Healthy families enrich a person's power, not diminish it. There is a clear recognition of each person's value and contribution to the power of the group. As a consequence, the power of the family is greater than the sum of the power of each individual member.

Healthy families are not democracies, autocracies, or anarchies. Such families strive for consensus, and while consensus may not always be reached, each individual has a chance to be heard. This avoids the "tyranny of the majority over the minority" often common to democratic families, as well as the obvious problems of autocracies or anarchies. This is not to suggest that healthy families don't have leaders; they do. It is usually one or both of the parents, but they are leaders not power-brokers.

Selvini-Palazzoli (1978) points out that the families of anorexics (and bulimics) often struggle with power. Typically, the family doesn't possess sound leadership, and the members waffle on the issue. Perhaps dad is the supposed leader, but mom is really the one in charge. It is never really clear who is guiding the family. The whole issue of power makes the family uncomfortable. Power has the connotation of a dirty word. More importantly, the children do not see themselves as empowered. Seeing themselves as caretakers, parents typically say in therapy, "Tell us what we can do to make you happy."

Most of my clients do not even know what personal power is. They see themselves as needing to be rescued, as "stuck." This is to be expected. If they have no background in making choices, in sharing power, it is no wonder they see themselves as victims. This, in turn, sets up the parents. No matter what they do, eating disordered clients perceive their parents as coming to the rescue with too little or too late.

The lack of shared power results in placing blame. Many times, parents say, "What did we do wrong?" Since the children aren't empowered, then someone needs to be at fault. Parents assume responsibility for the problem and they want you to tell them how to fix it. Clients always respond with, "It's nobody's fault." Although this is what they say, it is not what they mean. Again it points to the unclear nature of power within the family. At one level the client is saying, "I don't know who to blame." At another level, the client implies that it is everybody's fault including her own. All in all, blaming is a fruitless process. Everyone rushes up to take it, then whoever gets it feels resentful or guilty. The reason families do this is the misguided notion that laying blame on someone will enable that someone to fix the problem. It doesn't work. It becomes a game. A game I call "My Fault, Your Fault." And no one wins.

What can you do about this? First, confront the blaming head on. Second, don't become discouraged if the family continues to blame. Remember that they have been playing My Fault, Your Fault for years. You may be able to change the rules but not eliminate the game.

Degree of Individuation

Here Lewis et al. (1976) contend that healthy families respect individual differences. Each person is a separate individual with a different perspective of the family and of the world. This doesn't mean that healthy families always enjoy the differences. They may simply tolerate them. But the important points are that such families encourage individual growth and appreciate each person's uniqueness.

Minuchin, Rosman, and Baker (1973) find that families of the eating disordered are highly enmeshed. These families firmly believe in the adage, "all for one and one for all." You should not be an individual. You should define yourself as one of the Smiths, Joneses, or Olsons. Family membership often entails sacrificing your separate identity. But why should you need one; doesn't the family take care of you, love you, keep you safe?

My clients have been taught a list of should's: You <u>should</u> like this. You <u>should</u> do this. You <u>shouldn't</u> say that. You <u>shouldn't</u> feel that way. These should's are based on what is perceived to be good for the family and not necessarily what is good for the person.

Although an individual is allowed to ask about what to do, say, feel or think, somehow she is supposed to know already. Any deviation from the family's pattern is seen as desertion or, worse, betrayal. Deviation is punished covertly, via guilt induction. Most commonly, guilt is induced by statements such as "How could you do that to your mother?" "How could you be so selfish?" "Don't you know that we love you and we only want what is best for you?"

Under all of this lies a threat. Although it is never stated overtly, the punishment for deviation is abandonment--perhaps not physical abandonment, but the family sees the individual as not fitting in anymore. This fear of rejection often keeps the family members in line. It is your biggest block to helping the client attain a sense of selfhood.

When you see your client's family, it will be in crisis. The members will be scared and wary. They will say things like, "We don't understand. Janey was always such a good girl. Janey was always so happy and well adjusted." They will expect you to attack. Since they are so enmeshed, they will assume that if you think their daughter is "sick," so must they all be sick. Since they see what she is doing as "bad," then you will see them as bad.

Focus on seeing the whole family and yet make it comfortable for each member to be an individual. Insist that each member speak for her/himself. Don't focus on the past, stay in the present. Don't put the family on the defensive, or they will likely close ranks and become more enmeshed. If they do, you will be the enemy, instead of the helper. And you will lose because they outnumber you.

Acceptance of Separation and Loss

Lewis et al. (1976) state that healthy families "self-destruct." What they mean is that such families do not encase themselves in lucite. Members grow, change, die. Families grow, change, and are reborn. There is an understanding that life doesn't always remain the same. And if life changes so, too, must the family. Healthy families realize that children grow into adults, that parents die, and that new children are born. Such families are flexible and adaptable. These families may not like change, but they acknowledge its inevitability.

The parents prepare their children for change. They do so by teaching their children to make decisions, to value themselves, and to recognize the limits of their

power. By the last item, I mean that such families teach their children to know what they can control and what they can't. They teach them to sail on the river of life, rather than to fight it or dam it up.

The parents in such families celebrate their children's adulthood. They recognize their sorrow and loss as their children grow. Yet, they are able to applaud their children's maturity. They are able to let go.

The families of the eating disordered typically have problems in separating, in letting go (Kaluey, Crisp, & Harding, 1977; Minuchin et al., 1978; Yager, 1981). They cling to each other. Loyalty to the family is a paramount virtue. Individuals may go off to school, work, or to marriage. But they may not leave. They are to call frequently. They are to keep everyone informed as to their whereabouts and what they are doing.

These families purposely encase themselves in lucite by limiting the members' freedom to choose, to grow, to change. Change is the enemy. Change means that members won't be able to predict each other's behavior. They won't be able to influence each other's decisions. They won't be able to control each other's lives.

These families are studies in rigidity. They attempt to dam up life's river so that they will not have to experience flood or crisis. Yet this damming process requires a tremendous expenditure of energy. To do so, they must constantly surveil each other's movements. They must keep a nightwatch on the future. Not only change is the enemy, but the future as well. Families such as these live in dread of separating, of losing each other. If that were to happen, then who would they be? Where would they go? What would they know?

The primary building block of their dam is denial. If they don't acknowledge that Jane is getting older, then they don't have to deal with it. If they minimize dad's heart attack, maybe he will get better faster. If they deny mom has a drinking problem, maybe she will stop or at least keep it in line. They build their dam by denial; they maintain it by minimizing; they enlarge it by co-opting others into their family system. Boyfriends and girlfriends become new sons and daughters. Grandchildren are to be loved, protected, and controlled. And so the story repeats itself again and again.

You, as a therapist, represent a three-fold danger. You represent change. You represent a problem that no longer can be denied. You represent a future that is

unpredictable. Moreover, you represent a breach of family loyalty, a leak in the dam.

Don't expect them to greet you with open arms and beware of honey-coated arsenic. The concern the family members have for the "sick" member is real, and yet they do not want to change to promote her healing. They want to make Janey into what she was. They want to make their family feel the way it used to. They don't want to lose Janey. What is scarier is that some of the family would prefer it if Janey stayed sick. At least that way they can take care of her; they can keep her.

If Jane is successful in becoming independent from her family, the family blames the therapist. The following comment is typical: "Oh Jane, this couldn't be your idea. Mitzi put this in your head and she doesn't understand our family. This isn't the way you want to be. Maybe you should see another psychologist. One who understands you and your family better."

What do I do in this type of situation? I keep supporting my client's search for identity and I keep reminding my clients that their families are engaged in a dance. If you change the dance on your partners, if you start not keeping in step, you can expect hesitancy, having your feet trampled, and some even refusing to dance with you anymore. But most partners will adjust to the new dance. Being independent from your family doesn't mean you resign from it. You can't. It simply means that you choose to accept a new role. You are no longer only Jane Doe, daughter of Mr. & Mrs. Doe. You are Jane Whoever You Choose To Be. The search for identity is an exercise not in subtraction but in addition.

Perception of Reality

Reality, like beauty, is in the eye of the beholder. We learn about reality from our families. Our initial experiences in values, in stereotypes, in goals come from our families. Healthy families develop their realities by interacting, transacting, and reacting with the world and its people. They engage in a constant exchange of information both externally and internally. The parents' power is a shared experience. Members communicate to each other about the world as they perceive it. No one person's vision of reality is superior, perhaps only different. Difference of opinion is acceptable for it nourishes further communication, growth, and change. These families are open to the world of possibility.

Among the families of the eating disordered, you find a somewhat different state of affairs. The families are more insular. They are suspicious of the outside world. They carve a niche for themselves in their community. They are comfortable within that niche and seldom stray out of it. They attend clubs, churches, restaurants, and schools that their friends within their niche attend. On the surface they seem to be open, but a great deal of this is pretense. Parents pretend to be open to children, children to parents. And yet, so often, each is hearing only what s/he wants to hear. When the messages from inside or outside the family are in conflict with the preferred reality, the family usually discounts or rejects them.

If you remember my discussion of psychological development for Chapter III, I theorized that most of my clients have foreclosed on their own development. They have done so by co-opting the values of their parents in order to avoid conflict. As I have worked with my clients' families, I have found that foreclosure is common to the families in general. For years, the families have operated out of the value system of others—the values of their niche peers, the values of their families of origin. They have done this to avoid having conflict, to avoid being different, to avoid creating a sense of self. The parents, as well as the children, are stuck in adolescence.

As you begin to expand the horizon of possibilities for identity with your client, the families resist. The resistance arises out of fear, fear of change. Remember as well that Marcia (1976) contends that identity is achieved out of the dynamic tension between values and crisis. As you explore new realities with your client, this precipitates crisis within the family. Don't fear this. Crisis is exactly what the family needs in order to grow, in order for members to grasp their identity. Reality based on the status quo comes crashing down. Celebrate its fall. In its demise, the hope exists for rebirth for all, especially for your client.

Affect

Lewis et al. (1976) theorize that it feels good to be in a healthy family. Within such families, there is an emphasis upon the positive. Such families do not foster worry or doomsday thinking. There is a feeling of security which permeates such families. Because of this security, empathy is present. Family members feel secure enough to share themselves intimately with each other, without the need to hide behind masks.

Empathy and intimacy are most likely a result of each member having a sense of personal power. When we see ourselves as empowered, we also recognize our limits. For example, if you find yourself on a raft out in the ocean, you have several options. One is to feel overwhelmed and do nothing. This results in being a victim and allowing yourself to float willynilly. Another option is to rant and rave against the inequity of your predicament. This, too, results in accomplishing nothing but exhaustion and frustration. Another option is to do what you can with your situation by paddling with your hands, by rigging up a makeshift sail or rudder. In this final option, you are still less powerful than the ocean but you make your presence significant. Healthy families help to create individuals who are able to make themselves significant.

In the families of the eating disordered, there is a tendency for people to operate out of guilt or blame. Guilt is a way of denying the limits of power. If dad has died, the remaining family members often feel guilty They assume that if they had only done things differently, dad would still be alive. In this way, they refuse to acknowledge the ocean is larger than they, that there are limits to their power.

Guilt leads to blame. Blame is a way of giving away your power. If I say to my mother, "You give me a headache," I give my mother my power. What if she were to take it and say, "Well, if you think that is bad, wait till I give you a stomach ache and then cramps." If my mother says this, she is acknowledging openly my transference of power. Of course, mothers do not say this. Taking power openly is a breach of etiquette. It is too bad we don't use this approach. Think of how quickly blame would stop.

In the families of the eating disordered, etiquette is followed: guilt is assumed and blame placed. Each member is taught that self-denial, self-effacement, self-sacrifice are "good" things to do for the sake of the family. As a result, members are taught to hide their feelings and their personal power. Intimacy and empathy have become almost impossible since they are seen as threats to family stability.

Help your clients discover their personal power and their limits. Help them learn to forgive themselves instead of staying stuck in guilt. Help them focus that forgiveness outward so they can escape from the impoverishment of blame. Help them learn to celebrate themselves, to make themselves significant. If you help your clients learn a new dance, most of their family members will follow.

Before I proceed further, I want to make a few points concerning worry. Worry and fear of the future are common to my clients and their families. I once heard a spiritual teacher define worry as "satanic prayer." He believes that worry is the absolute faith that God is going to screw up. It is a conviction that the world is set up totally incorrectly and that the worst is going to happen. Worry takes a great deal of energy and results in each of us minimizing our significance. It is a belief that we cannot make a rudder, a sail, or a paddle for our raft. Worry either immobilizes or creates what Shakespeare referred to as "sound and fury, signifying nothing."

Help your clients realize the self-defeating nature of worry. Help them focus on today and leave tomorrow where it is. Don't play the "what if" game with them. If they start catastrophizing, affirm that indeed all those bad things may happen. Don't rescue; don't console. Let them realize that right now is what they have control over. If they start focusing elsewhere, they lose control. They are neither prisoners of their past nor victims of their future. Worrying about bridges before you come to them results in paying the toll twice.

Before I leave this section, I want to state emphatically that what you have just read is generalization. Each family is different and unique. Your clients' families are not exceptions. Not all of them are dysfunctional. Not all of them evidence the pattern I present. I trust that you will not label such families as "bad" or "sick." They are simply families. If you discover how they operate, that knowledge is useful in aiding your client's growth. Use the information as a guide and not as dogma.

Intra-Family Dynamics

Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) present a family model which focuses on psychosomatic illness in children. I find this model particularly helpful in working with my clients and their families. They propose three crucial points: the child is physiologically vulnerable; the family has a particular style of interaction; and the sick child plays a crucial role within the family.

Physiological Vulnerability. As Bruch (1973) points out, our eating patterns develop within a family structure. Most typically, my clients come from families where slimness is important or at least weight is focused upon. My clients remember

being ridiculed as children or adolescents about their weight. They report parents who were constantly dieting, worrying about their weight, or giving a host of reasons why they were overweight. Siblings, too, are highly weight conscious.

Food was (and perhaps is) a central issue in their families. Affection is often shown through food. The "bake someone happy" phenomenon has become part of the family scene. Power, too, is often exerted through food. Many of my clients were told to clean their plates. Their portions were placed on their plates. They were not often allowed a great deal of choice or control over food. As they aged, comments were made about their eating habits and their food choices. They were subjected to lectures about gaining weight, fattening foods, etc.

No wonder these young people become physiologically vulnerable. On the one hand, food means love and acceptance. On the other, it becomes the enemy and a power issue. It makes intuitive sense that, as these young men and women mature, they begin to experience problems with eating. For the anorexic, refusing to eat is an enormous power play. For the bulimic, losing control around food is understandable. Food represents emotional nurturance, but it is a nurturance based on fear.

Family Interactive Patterns. It is my experience and that of others (Bruch, 1973; Yager, 1981) that a particular parenting pattern exists within the family. I find the mothers to be overinvolved and fathers underinvolved. This is not to place blame on either parent; it is simply a pattern. Moms want to know details about their children. They ask about friends, food, school, clothes, on and on. The children have little or no privacy. This pattern is longstanding and the mothers are well-intentioned. They are doing the job of two parents. Dad is usually there but not always present; it is not that dad doesn't care, but he is at a loss to show his caring. He works; he watches television; he reads the newspaper; he offers advice; he rescues but he is usually not intimate. The lack of intimacy becomes more pronounced as the children enter adolescence, especially with his female children.

It is interesting to note that both my anorexic and bulimic clients fall into four distinct categories where their fathers are concerned. In about 15% of my clients, the father is deceased. In 18%, the parents are divorced and dad was the "throw away parent." In 24%, they never had a close relationship with their fathers. The remaining 43% experienced their fathers pulling away from them as they entered adolescence. At one time they were close to their dads and did a variety of things with them—they were their fathers' "little girls."

In all four categories, dad is missing and mom rushes in to fill the gap. It is obvious how the death of a parent often creates guilt in a child. Guilt and withdrawal are equally obvious in divorce situations. The last two categories are more complex. In both cases, the child perceives herself as abandoned. During adolescence, a girl continues to need her dad as she learns how to be a young woman and to discover intimacy with men outside a sexual context. It is no wonder that a girl approaching young womanhood whose father has withdrawn chooses a behavior that results in arresting maturity and negating intimacy.

In therapy, attempt to foster a new and deeper relationship between your client and her father. If dad is no longer available due to death or divorce, focus on the guilt-anger issues surrounding your client's sense of abandonment. Focus on the mother's overinvolvement. Stress the need that children have for privacy. Many times I find my client telling her mother everything without even having been asked. This is a learned behavior which the client often feels guilty for not doing. Help your client start making choices about what to keep private. This often involves training her in assertion, i.e., how to say "no" without anger, malice, or self-abuse.

Other issues relevant to the family pattern are enmeshment, overprotection, rigidity, and avoidance of conflict or, if it occurs, the lack of conflict resolution. Enmeshment, as discussed previously, refers to the lack of perceived, separate identities within the family. You find mom speaking for dad, your client speaking for parents, etc. Everyone is into "mindreading," and often it is poorly done. Many of the assumptions about what somebody else is feeling or thinking are inaccurate because the conclusions are based on what one fears the others are feeling or thinking, not on what they are, in fact, experiencing.

Overprotectiveness is common among all family members. Again, this arises because of fear, a fear of the outside world. Parents give mixed messages: they set up goals for their children, and then they question their children's capabilities for reaching them. They worry that their children might get hurt, might not make it. The result is that the children doubt themselves.

These families are rigid. Rules are for everyone. If the family decides to go on vacation, everyone must go. If the family goes out to eat, everyone must go. The list goes on. The reason that rules are rigidly adhered to is to avoid unfairness. Remember the adage of all for one.

These families avoid conflict. Everyone is into pleasing everyone else. This leads to inner feelings of hostility or anger since trying to please others usually results in not pleasing yourself. Dad feels ignored; mom feels dumped on; the children feel discounted. Since hostility is rarely openly expressed, typical patterns of handling it include: withdrawal, joking, teasing, pouting, and punishing via passive aggression.

Family Roles Played by Clients. Minuchin et al. (1975) propose that clients typically act out one of three common roles. These are triangulation, parent-child coalition, and detouring.

In triangulation, your client feels trapped. The client fears expressing herself because such expression is tantamount to taking sides. She does not want to come between mom and dad. And unfortunately when she does speak, that is exactly what happens. Or at least the side-taking is what the parents perceive. Typically, the parents are in a coalition against their child. Obviously, it is lonely and isolated out there. These feelings tend to exacerbate the eating disorder.

A second pattern is the parent-child coalition. Your client moves into a stable alliance with one parent. The child and one parent now form the base. They become the parent and the other parent is on the lonely apex. Selvini-Palazzoli (1978) refers to this as a three-way marriage and even more descriptively as "psychological incest." Your client tries to make up for the shortcomings of the isolated parent. The child attempts to replace the banned spouse. It is a witchhunt that results in one parent being burned at the stake. "Obviously dad is the villain because he is never home and he doesn't care about us." "Obviously mom is the problem. If only she weren't so overcontrolling, so snoopy, so demanding, everyone would be fine."

The last pattern is an act of subterfuge. The parents unite and then focus their attention on their "sick" child. They hide their conflicts and insist that their child's eating problem is the <u>only real</u> family problem. Their focus is either blame or overprotection. Of course, this is nonsense. And yet, families practicing detouring are sure they have no other problems. Even your client believes this. In fact, your client often is "sick" to save the family from having to focus on other issues. Since such families are inept at resolving conflict, being sick switches the focus. That way, your client is protecting the family from issues that might not be so easy to fix. The child becomes the martyr.

Family Responses to the Problem

Early in this work, I likened the eating disorders to chemical addictions. I have found the chemical dependency literature, especially in the area of family systems, to be extremely helpful (Chemical Dependency, 1978; Wegscheider, 1983). Particularly important to my work has been the concept of enabling.

As concerned family members react to my client's disorder, many unwittingly aid the dis-ease process and enable it to continue and flourish. In order to protect themselves against the painful feelings due to my client's problem, they adopt one of three defensive strategies: being too good to be true; being rebellious; or being apathetic (Chemical Dependency, 1978).

Being too good to be true is a way to camouflage the problem. If other members are really nice and well put together, then maybe no one will realize the family has a problem. It is an attempt to fix the addicted person. Parents often think to themselves, "If I am a better parent, if I do all I possibly can, then maybe my child will get better." Being too good is a way to get attention. Usually the entire family focuses on the eating disordered member. How then do other members get the attention they need? One way is to try to be so wonderful that everyone will have to notice.

The Johnson Institute (Chemical Dependency, 1978) provides a good working list of the types of behavior typical to this defensive strategy:

- Achieving for the family, in school, at work, in sports, in the community.
- Doing more than one's share around the house.
- Counseling the family, patching up family fights and relationships.
- Being cute and funny at inappropriate times, entertaining to relieve stressful situation.
- Struggling for perfection, not allowing for any mistakes, denying mistakes.
- Intellectualizing, acknowledging family stress and pain only on a thinking level, denying feelings about the stress.
- Parenting, children acting as parents, disciplining other children, worrying about family finances, adults acting as parents to other adults.
- Meeting everyone's expectations, trying to keep everyone happy.
- Being rigidly obedient, always following all the rules. (p. 15)

The above behaviors are especially prominent in my clients' families. Interestingly, being too good to be true is a pattern common to my clients before the onset of their disorder. It is one they try to continue even in the throes of their disease. Of course, the physiological and psychological consequences of anorexia or bulimia make their chosen role almost impossible. My clients who are too good to be true are protecting the family. How could Jane have a problem when she does so well in all she tries.

What is unhelpful about this strategy? Most often, the members who are being too good protect the afflicted family member from experiencing the consequences of their behavior. This makes it easier to stay bulimic or anorexic.

Another strategy is to be rebellious. This pattern most often occurs (if at all) among the siblings. The rebellious individual diverts attention away from the eating disordered member. It is also a way to hide pain. These individuals adopt an attitude of "nobody can hurt me." Again the Johnson Institute (Chemical Dependency, 1978) provides a list:

- Being dishonest.
- Being late for work.
- Acting out in school and at home.
- Breaking house rules.
- Being defiant of authority at home or on the job.
- Starting arguments with neighbors.
- Being a bully, playing hurtful pranks.
- Bossing the neighbor's children.
- Rejecting the family, developing a "family" of friends of whom parents would not approve.
- Neglecting one's children or becoming abusive. (p. 18)

The final common strategy is apathy. Apathy usually starts as denial. There are limits to how long one can deny the gallon of vanished ice cream, the remains of vomit on the toilet, the emaciated body of an anorexic. And yet those limits can be extreme. I remember a client who had been actively bulimic for 15 years. I remember her husband insisting that he had no idea she had a problem. Now this man wasn't blind or deaf or noncaring. To protect himself from his inability to do anything, he just chose to ignore the problem. His behavior was not exceptional or bad, just sad. Yet even he had to abandon denial and then of course became apathetic.

Most individuals who choose the apathetic route don't do much of anything. They withdraw from stress, from the affected individual. They seem to be calm, controlled, and philosophical. They protect themselves with an "I don't care" attitude, but internally, they are anxious and overwrought. Mothers seldom assume the apathetic role; fathers do so with a high frequency, as do siblings.

Family members need to be aware of these enabling strategies and how these strategies help to maintain the problem. As a therapist, you are not immune to enabling either. Read what Wegscheider (1983) writes about chemical dependency counselors and take heed for your practice with the eating disordered.

> Even though the community system exists to provide services to the other two systems, it can also subvert its own best intentions--it can enable the alcoholic. Counselors belong to the community family system, and there are many who bring their own unresolved personal and professional self-doubts into treatment.
>
> With these self-doubts operating on his psyche, the Counselor sets out to win the approval of the alcoholic family. Easy answers for his clients may spring to his lips and this encourages their approbation of him. But the family system remains sick, and at this point he may even enter it. He will take responsibility for the Dependent, admire the Enabler, and even reject the Scapegoat. Finally, it becomes apparent to all that the Counselor has failed. He is rejected by the family, by his colleagues, and even by himself. This same sad situation can occur with inexperienced or unwary psychiatrists, ministers and social workers.
>
> Dealing with alcoholic families requires a commitment on the part of the counselor to unflinching honesty. He must be willing to help them experience the pain as well as the joy of each moment. He must be objective; he must let them take responsibility for the changes they are going to make; and ultimately, he must let go of them. (p. 30)

Family Therapy Techniques

This final section provides you with some general guidelines, and it is not a "how to" approach. Now that you are familiar with some possible family dynamics and patterns, you may find these suggestions helpful. They are a composite of the work of Liebman, Minuchin & Baker, 1974; Minuchin et al., 1978; Selvini-Palazzoli, 1978; Yager, 1981; and my own.

First, get rid of the mystery surrounding the disorders. I suggest you set the problem in context. Discuss with the family how the disorder is affecting each member, how each member may be enabling the client. Focus on what the limits of control and responsibility are for each person.

Second, assess where each member of the family is functioning developmentally. Design tasks that fit each one's developmental level. For example, if you find one or more of the children "parenting," discourage this. Focus on problem solving and set the stage so that your client can demonstrate competence. Don't inundate your client with power that she is not ready to assume.

Third, explore the family's pattern of response to the problem. Enact a situation in therapy that is a typical problem for the family. Observe how they interact, what roles they play, and how they enable. Share with the family your observations and explore with them alternate ways of behaving.

Fourth, work on the power dynamics. To this end, I usually suggest that family members adopt the following guidelines.

1. Allow the eating disordered member control over her eating. Discourage family members butting in with their opinions or comments about food choice, food intake, weight, etc. The client needs to learn responsibility for her own behavior. Besides, trying to control is a fruitless process. It only tends to increase the eating disorder.

2. Make the eating disordered member aware of the consequences. For example, if your adolescent anorexic continues to lose weight, then she must go to the hospital. If the member is older than 18, the parents need to state what personal consequences will ensue; such as, "If you binge and vomit while you are home, you will have to leave."

3. If the family member is bulimic make that person responsible for her own habit. If she needs to binge, that is her choice. However, she needs to supply her own food. Binging on the family's food is the same as stealing if the person purges after eating. It is no different from throwing out a gallon of ice cream that cost $2.59. Family members need to confront binging on family food and treat it as stealing.

4. The bulimic client needs to be responsible for cleaning up after herself. It is not acceptable to have vomit swim in the toilet, a bathroom that reeks of vomit, or containers of vomit in the garbage. This intrudes on the rights of others.

5. Don't tease or ridicule the person about the behavior.

These rules help to demarcate who has control and responsibility over what. They also stress that each individual has rights and those rights don't include dumping upon others.

Fifth, determine how adequately the family members are meeting each other's emotional needs. Focus on teaching the members to risk asking for what they need. Also emphasize that if someone chooses to say "no," it is not a rejection of the person; it is a rejection of the request. The fear of personal rejection is what stops each member from asking.

Sixth, look for abusive or addictive patterns in the other family members. Eating disorders, like chemical addictions, often run in families. In my practice, I find 22% of my clients have a family member who is also eating disordered. In 16% of my clients, someone in the family is chemically dependent. Don't overlook these crucial issues.

Chapter VI
GROUP THERAPY TECHNIQUES: STRENGTH LIES IN NUMBERS

This chapter focuses exclusively on group therapy techniques that I and others have developed over the last four years. It is not the only way groups for the eating disordered can or should be organized. It is the way my co-therapists and I have implemented our program. The program reflects our environmental limitations and our therapeutic biases. A discussion of these areas is necessary to understanding our approach.

First, we are located in a small, midwestern city of less than 100,000 people (Duluth)--and therefore not blessed with an eating disorders clinic. Although such clinics were available in Minneapolis (about 180 miles away), the distance, the cost, and the waiting lists often prevented people from going to them. To compound our difficulty, there were only a handful of therapists (psychologists, counselors, psychiatrists, or social workers) working with eating disorders in Duluth. Many therapists have shied away from this population for a variety of reasons, from fear to ignorance and everything in between.

Given this situation, there was a tremendous need to start a program in the area. Candidates for the group were not a problem, as Duluth is a university town. I had bulimics and anorexics coming to me in droves. Word spread not only through the student network but also through the media. Fortunately, I began the program just as the media was becoming interested in the disorder. I was interviewed by local radio and TV stations numerous times. I also began an educational program at the Duluth campus of University of Minnesota and at the College of St. Scholastica. I spoke to classes; I did inservices for the health services and chemical dependency programs; I agreed to newspaper interviews. Perhaps I got the word out too well, for I was often hard-pressed to meet the client load.

Originally, I ran the group program alone. This was a mistake. I was not able to meet the diverse needs of the clients. I was overworked too often. When clients needed to be hospitalized or when they spun out of control, I made the error of taking these events too personally. I had few professional suppport systems. And all the time, I was experimenting with methodology and technique.

During that first year, I felt as if I were blind and trying to grope a path for blind fellow voyagers. The stress was unbelievable, and I believe it was not coincidental that in the spring of that year I suffered a stroke. After my recovery, I started out anew. I elicited help from nutritionists, a psychiatrist, and graduate students, and I hired a co-therapist. As a consequence, not only did I recover but "our" program was vastly improved. It was a hard lesson to learn, but out of it came a tremendous amount of positive energy and growth.

The personal biases of my co-therapists and me are reflected in our program. My co-therapists received a majority of their training within a chemical dependency framework. My training as a psychologist was highly eclectic. It was an integrated combination of experimental, clinical and developmental approaches.

As a result, our program focuses on the addictive nature of the eating disorders. We work a modified 12 Step Program that we borrowed from Alcoholics Anonymous. The program also attends to assessing the developmental level of the client along with a strong experimental flavor in modifying and adapting methodology.

Setting Up a Group

Before you begin a group program, I suggest you focus on the following: (1) what type of group you want, either open-ended or time-referenced; (2) how often you plan to meet; (3) what, if any, fee will be charged; (4) who should be in the group; and (5) guidelines for group membership.

First, let's focus on type of group. Several of the major eating disorder clinics utilize a time-referenced program (Cauwels, 1983). The University of Minnesota Hospital program is a respected leader in outpatient treatment. That program is intensive and lasts two months. During the first week, clients attend group sessions five nights a week. Then they attend four nights during the second week, and three nights the third. During the fourth week they meet three nights, two in group therapy and one in an Overeaters Anonymous format. During the fifth through eighth weeks, there are two nightly meetings, one a therapy group and one the O.A. group. After finishing the two month program, clients can elect to go into a follow-up group for three months. This program is not only time-referenced but also sequential.

Currently, we do not have the resources within our community to have such an intensive program. Our groups meet only once a week for two hours. Many clients also receive individual therapy during their group experience. Our group is open-ended. Due to the smaller size of the community, a limited number of therapists, and variations in demand (according to the university/college calendar), we find it difficult to set up a program of specific length. Therefore, people come and go into the group as they are ready.

How often your group meets depends on your resources. If you have the available counselors and the finances, I suggest your group meet at least twice a week. If resources are minimal, running an open-ended group more than once a week can be burdensome.

Our group is a therapy group and therefore a fee is charged. As I have said, it is my conviction that putting a monetary investment into healing is beneficial and therapeutic. It is too easy for a client to minimize the import of therapy when it is free. The fee serves as a constant reminder of the need for continued progress. Our fee schedule is adaptable and no one is ever refused treatment for monetary reasons. If you are working in a setting where it is not possible to charge a fee, I suggest that each session your clients contribute to their "graduation fund." That is, after their completion of your program, they are given back the money they contributed. Don't underestimate the healing power of money.

You need to decide what the composition of your group will be--whether to have separate groups for anorexics and bulimics or whether to include both disorders. Some groups also include obese individuals who binge. You need to decide whether your groups will include males. Our group is a mixed group in terms of both the eating disorders and sex. We did this out of necessity. We don't have a large enough anorexic population to warrant a separate group. The same is true of males. It is our experience that there are more similarities than differences between both the disorders and the sexes.

There is a caution to note: Age is an important factor. We find that clients 17 and younger do not do well with an older group. Since the majority of our clients are bulimic, the average age of the group members is 22. There is a world of difference between the developmental tasks of 14 and 22 year-olds. I suggest that you run a separate group for the younger adolescents.

Group Guidelines

Setting up guidelines in many ways entails setting up structure. Beware of having your structure too loose. Remember that your clients are experts at impression-management and manipulation. When the group rules are explicit, there is less opportunity for your clients to plead ignorance or misunderstanding.

Originally, our only requirement for entry into the group was the desire to recover. We did not insist on abstinence although it was strongly encouraged. We sought only to provide a safe healing environment. Although such high principles sound wonderful, they didn't work. First, we found that as people shared the intimate details of their binge-purge or fasting techniques, group members often perceived it as permission to experiment. We ended up with a number of clients who got better, but they got better at being bulimic or anorexic and not at recovering. Second, we found that we were inadvertently enabling the disorders. Reasoning such as the following was typical: "Well, I have a problem. I am bulimic. I am still binging and vomiting, but I'm getting better. Besides, I am going to this group for help." As long as clients saw attending group as doing something constructive, something that would "fix" their problem, they didn't have to "own" their recovery. They used going to group as a cover to continue their problem. For those reasons, we began to require demonstrated abstinence for admittance.

We are very explicit about abstinence. The person has to work with a therapist individually before being admitted into group. The length of time in individual therapy varies; most clients need at least four to six one hour sessions, some less, some more. During these sessions, we set the stage for abstinence (as discussed in Chapter IV). Furthermore, we require that she see a dietician and her physician. The goal of all this is to have the client experience at least two full weeks of "being clean," i.e., no binges, no purges, no fainting, no dieting behavior. This is the minimum requirement for group admittance. It works well since we limit our group size to ten and can use any time spent on a waiting list constructively.

We further delineate abstinence once the client comes into group. Colloquially, the rule is "three strikes and out." This means that if a bulimic client binges or purges more than twice while in group, she has to leave, but not permanently. Notice that we require leaving for binging or purging. We are trying

to eliminate food abuse, not just vomiting. The first time, the leave has to be for a minimum of three weeks. It can be longer if the individual feels more time is needed.

In the case of anorexics, we require either a weight gain or weight stabilization. If she does not show the prescribed weight gain at the end of three weeks, she has to leave for three weeks. If she is on a weight stabilization program after three consecutive weeks of weight loss, she leaves.

The leave of absence is highly successful. It provides the client an opportunity to assess what she needs and wants without having to acquiesce to group pressure. It is a time to re-affirm her commitment to herself. We usually suggest that she see one of the therapists individually during her leave. The remaining members call and check in with her on a daily basis--she is still part of the group, just not in it.

During the last two years 57% of the group members have taken the initial leave. Of these, 93% return. We do lose a few individuals, the majority of whom are anorexics. The ones who return are renewed, re-energized, re-committed.

If an individual continues to experience problems after the initial leave, we leave the decision about what to do up to that person and the group. We keep this process open-ended. Typically, the individual decides to take another leave and the length of time is negotiated by her and the group. The therapists stay out of it, although occasionally (three times thus far) we request individuals to leave permanently. Here we make a referral to a more intensive outpatient program or to an in-hospital clinic. We do so when the person is simply making little or no progress. Such a decision is in the best interests of the client. Some people need more help than we can give them.

You may wonder if clients lie about their abstinence. Of course, they do. Many times the bulimic individuals come to group and pretend that they are neither binging nor purging. Don't let this worry you. These young people possess a high degree of integrity, and in their own time they let the group know the truth. It is a very painful process to participate in group and pretend. The lie becomes increasingly burdensome. We do not chastise anyone for not telling the truth. We focus on the issues of binging and vomiting and how to handle them.

Anorexics have a more difficult time in lying since they weigh-in. However, as I mentioned previously, they occasionally use measures to manipulate their weight. This, too, eventually comes out and again we handle it without chastisement.

There is no reason to punish. These individuals are already experts at self-punishment. Focus on stopping that self-punitive behavior and getting them to realize how self-defeating it is. Do not present the leave as punishment. It is a time to reflect, to grow, to seek more intensive individual or family therapy. It is a time to realize that the disorder is bigger than the client is and she is powerless over it. She cannot continue the abusive pattern in moderation. She must stop or not stop. Saying that she'll try has got her nowhere. When people say they are going to try, they usually mean they are not going to do something and do not want to accept the consequences of not doing it. The leave is a time to find the courage to say yes or no to one's recovery.

Entry into an open-ended group can be a difficult process. The person may feel like an "outsider." To make the process easier, we have adopted the following procedure. First, at least a week before someone comes into the group, we make an announcement to the members. We share some biographical information about the new member with the group. We then ask if anyone feels comfortable being the person's sponsor. That individual then calls the new member and sets up a meeting. In this way, the newcomer has a special relationship with one member before her initial group session. This makes the introduction to the group easier, and often the sponsor provides support similar to a Big Sister program.

Originally, we had newcomers share their stories at the first session. This was often difficult for them. They were nervous and edgy, and their stories were edited. Either they were overcome with feelings, or their stories were expunged of feelings. Due to these extremes we have dropped the requirement unless the individual wants to do so. We racked our brains searching for another way. We wanted the individuals to speak; we wanted them to feel a part of the group quickly. We did not want them to hang back in silence or to come in and commandeer attention. Finally, we settled on the following format.

We have everyone draw a family picture. The guidelines are simple and straightforward: Draw a picture of your family of origin as you see them. Align people up by who is closest to whom. Make sure you include yourself and where you fit within your family. If someone is dead or gone, include her/him as well, especially if you still think about the person a lot. If you are currently in a relationship, married, or have children, include these people too.

If there are typical messages you receive from a family member, include those. Do it as if you were drawing cartoon dialogue. Some messages might be: "Do you understand?" "You are never good enough." "Do you know, I only want what is best for you?" These are only examples.

Don't worry about the artistic part. Stick figures are fine. This isn't an art contest. It is a way to begin sharing with the group, and the picture will make sharing easier.

We find this to be a highly successful technique. It not only makes initial sharing easier but also results in a high level of intimacy. A picture is worth a host of words. It tells a great deal about the person, as she is sharing a central part of herself. Each group member examines the picture and is free to ask questions or to make comments. It is a wonderful tool to start dialogue. The members are especially perceptive--they pick up missing arms and hands and note size differences. Often they share with the newcomer how their families are similar.

We ask group members to abstain from mood-altering drugs such as alcohol during their tenure in the group. We do not police this but we ask about it. Since a number of these people experience chemical dependency (Dr. E. Eckert reports that 34% of the individuals are chemically dependent at the University of Minnesota Hospital Eating Disorders Clinic), we monitor their drug usage. If people are experiencing problems, it usually comes out. When it does, we suggest placement in either a local outpatient or inpatient chemical dependency program. I agree with Dr. Eckert that chemical dependency should be dealt with first because the problem so impairs the individual's ability to function ("Eating Disorders," 1983).

We also suggest during their first two months in group that they refrain from getting involved in new romantic relationships. Many clients become highly dependent on boyfriends, and we find that dealing with their dependent nature helps avoid future dependencies. Too often a client has left therapy when she got into a new relationship. She stated that she didn't need it anymore, that she was better since so-and-so came into her life. Usually, the eating disorder did abate--the new lover replaced her "fix." But the relationship didn't last and the person would come back because once the relationshp ended, the eating problem would dramatically and often viciously reappear.

Now, we cannot police either chemical use or new relationships. We simply share the reasons for our warnings with the clients. The rest is up to them. Our experience suggests that if either happens, it usually provides a good healing crisis for the client.

We strongly urge regular attendance at group. We insist they call one of the therapists in advance if they can't make a session. If they do not, we charge them anyway. People are free to leave group whenever they like. If they decide to leave before they are finished, we request they come to group and say goodbye. We follow up people who miss two consecutive meetings. If they have decided to leave, I ask to see them individually for a de-briefing. This is as much for me as for them. I don't like loose ends. It also enables me to let the clients know that they are free to come back if they need to do so. I don't try to pressure them into staying. They are the best judges of what they need. I don't interfere. They experience enough over-involved guidance from their families. I find this approach results in 80% of the clients returning to group. So it works. Applaud their independence and, perhaps, they will independently choose to return. But don't let them slip out like nomads in the desert; they need to learn to say good-bye. They need to learn that they aren't hurting our feelings. We care about them regardless of their decisions. They need to learn to take responsibility for themselves.

We require each group member to call a different group member each day. This increases the cohesiveness of the group. It also results in a continuation of group sharing in the absence of group sessions. We require calling a different person each day for obvious reasons. It is important to try to avoid the development of cliques. We ask the members to hand in a list at each session of the people they have called. This enables us to keep on top of cases where some individuals might be excluded. If we find this happening, we discuss it openly in group and seek solutions. I suggest that you require and not just advise calling, especially if you can't meet several times a week.

We also insist that group members see the dietician at least once a month. If people are experiencing difficulty with their nutrition, have them see the nutritionist more frequently.

Educational Focus

Each group has a portion of the time devoted to education. About once a month, the nutritionist covers the educational portion of the group. What the dietician discusses is often the result of expressed interest on the part of group members. Common topics include meal planning, the effects of sugar and salt on the body, adapting recipes to the exchange system, and analyzing the diet for adequate nutrients. Ask your members what they want to learn.

In addition to nutritional information we cover the following topics: family dynamics, dependency, stress management, women's issues, depression, feelings, sexuality, and assertion training. Since you are likely to be familiar with these topics, my discussion of each is brief.

We discuss family dynamics in detail. We focus on rigidity, power, loss and separation, enmeshment, and enabling. We encourage members to share their own experience. We make handouts of the Johnson Institute publication, Chemical Dependency: A Family Affair (1978). We use this as a basis of discussion. We have members analyze how their disorder has impacted upon their families. We get them to focus on both the positive and negative outcomes for themselves and their families. It is my contention that this topic is extremely important and needs a number of sessions devoted to it.

Dependency is an enormous issue. These people have addictive personalities and they need to be aware of that. We focus on why people seek dependency. They do so because of feelings of inadequacy, fear of not being okay or good enough, guilt or shame. We find Peele's book, Love and Addiction (1976), helpful in exposing the clients to the notion that dependency isn't always limited to substances. They are dependent on families, friends, lovers. They need to learn how to be both independent and interdependent. For those who think they are independent we discuss counter-dependence, the technique of hiding dependence under a mask of independence.

We help them find behaviors that they can engage in to develop greater self-confidence. We usually do this in the form of homework that they report on in the next group. One exercise consists of having them answer requests with yes or no and to eliminate maybe. Then they are to follow through on what they have committed themselves to. Too often, they overcommit themselves. They have difficulty in

saying no because they fear being rejected or not liked. They need to learn to say no without offering excuses. They need to stop hiding behind excuses such as "I'm too tired."

As I mentioned earlier, we use Tubesing's Kicking Your Stress Habits (1981) as the resource for our stress sessions. We work through the entire book and assign chapters and homework for each session. We focus on stress management and teach relaxation techniques, especially meditative breathing exercises, positive imaging, and centering techniques. We educate about the relationship between stress and illness, especially the illness as a result of their eating disorder.

Women's issues are extremely important components. Such issues include a belief in second-class status, differing realities, dependency in women, the pressure of being female in the age of "superwomen." We use Schaef's Women's Reality (1981). Schaef covers the "original sin of being born female," how men and women interact in relationships, and how women differ from white males in defining time, relationship, power, responsibility, sexuality and a host of other topics. When we have men in the group, we use the same resource. Schaef's book focuses on men and women. Our discussions are far richer when men are present for their presence encourages dialogue. We do not present men as villains but as victims, too.

We also use Kanter's A Tale of "O" (1980). This work focuses on what it means to be different within an organization. We modify this to include being different within your family, among your friends, etc. It also is available on slide or videotape. It is an extremely useful tool to aid all of us in seeing what happens to us when we are isolated. It offers concrete ways to cope with being different.

We educate about depression. We discuss the relationship between depression and physiological states. For example, we are currently collecting data about the incidence of premenstrual syndrome (PMS) among our population. PMS is a hormonal disorder with a wide array of emotional and physical symptoms. At the same phase of each menstrual cycle, women with PMS may experience:

- Tension
- Depression
- Anxiety or panic attacks
- Irritability
- Crying for no reason
- Fatigue
- Forgetfulness or mental confusion

- Clumsiness
- Cravings for sweets, carbohydrates, salty foods or alcohol
- Water retention that may cause breast tenderness, bloating of the stomach, ankles, feet, or fingers and joint pains
- Headaches, backaches, acne, cold sores, sties, sinus problems, asthmatic attacks and seizures

The causes of PMS are unknown but Dalton (1977) thought that women suffer from PMS because they lack sufficient amounts of progesterone, a female ovarian hormone. Many women respond well to progesterone therapy. If our clients are experiencing any of these symptoms, we refer them to a gynecologist with expertise in the area.

Diagnosing PMS requires keeping a daily calendar not only during menstruation, but for the entire cycle. No conclusive medical test is available. The timing of symptoms in each menstrual cycle is crucial to the diagnosis of PMS, as is the consistent absence of symptoms postmenstrually (Reid & Yen, 1981).

We discuss other physiological problems that can result in depression such as hypoglycemia, illness, and stress. We focus on how the clients can take care of themselves when they are depressed. We ask them to reach out to group members when they experience depression. We teach about the healing effects of laughter. We instruct in how to deal with depression, not necessarily how to avoid it. Periods of depression are normal and often can be predicted. Focus, then, on ways to minimize the consequences. We often call depression "sickness of the spirit." Have your clients attend to ways to feed their spirits with beauty, laughter, peace, and compassion.

Feelings, or more accurately hiding or masking feelings, are crucial issues. To aid in our discussion, we ask them to keep a journal of their feelings. We ask them to label their feelings and what they did with them. We teach about the fact that having feelings and putting them into behavior are two decidedly different things.

They need first to distinguish feelings, label them, and then make decisions about what to do. They need to own their feelings. Too often, they dump them on somebody else by blaming. "Mom makes me so mad." "John hurt me so deeply." They need to practice saying, "I am angry with mom." "I am hurt when John does that."

They need to learn to risk. One of the clients of Boskind-White and White (1983) wrote the following about risking:

> To laugh is to risk appearing the fool,
> To weep is to risk appearing sentimental,
> To reach out for another is to risk involvement,
> To expose feelings is to risk exposing the self,
> To place ideas and dreams before the crowd is to risk loss,
> To love is to risk rejection,
> To live is to risk dying,
> To hope is to risk despair,
> To try at all is to risk failure,
> But risk we must
> Because the greatest hazard of all is to risk nothing,
> For those who risk nothing do nothing, have nothing, are nothing. (p. 149)

Two resources are particularly helpful--Viscott's Risking (1977) and Kennedy's If You Really Knew Me Would You Still Like Me? (1975). Both books are easy reading and are full of suggestions. We assign them to be read and design homework around them.

Many of our clients need to learn to be assertive. There are a host of good books available on the topic. We find role playing the most helpful in-group activity. It is a lot of fun. And your clients need the laughter to overcome their fears.

Sexuality is a major problem area for clients. One treatment center in White Pine, Michigan, reports a 75% incest rate (personal communication, 1983). The topics of rape, incest, and abortion need to be addressed in an open and caring manner. Sexual preference needs to be explored; 19% of our clients are lesbians. We not only educate our clients about sexuality, but also make it comfortable for them to explore their sexuality.

As I mentioned earlier, before someone "graduates" from group, she must share a complete sexual history with the group. This task requires courage, intimacy, and self-confidence, all of which are tools they will need when they leave group. We ask them to write their sexual histories but to relate them to the group orally. We suggest that they focus on their earliest sexual memories and their sexual attitudes and habits, and that they assess any sexual patterns they have developed.

There is a great deal of fear about this assignment. Yet the relief that comes when they have finished is dramatically therapeutic--they discover their similar experiences. We focus on liberating them from the shame associated with their sexuality. For many of our lesbian and homosexual clients, this is usually the first time they've come out of the closet, and they find that people still care about them.

We stress that sexuality implies choice and that it is something to be enjoyed, not endured or abused. They need sexual confirmation. They are also woefully ignorant, and many need information about birth control. About 32% of my clients are virgins. They usually protest that they don't have anything to share, but, in fact, most experience shame about their virginity. In these cases, we stress that sex is far more than intercourse. Have them focus on what they feel and think about sex and have them examine their reasons for celibacy. Celibacy is a legitimate choice as long as it is a choice. So often it is the result of fear.

I suggest you share your own sexual history as well. So often clients look at me and say, "You mean, Mitzi, that you feel that way too. Gee, I thought you were so well put together." Share your humanness with them. As one of my professors once said to me, "Mitzi, when you become a clinician learn to share yourself without fear." I replied, "But what if I'm afraid." He said, "Share your fear." Share your fear and your joy. It works.

Therapeutic Devices

We work (and I mean work) the 12 Step Program borrowed from Alcoholics Anonymous. When we decided to adopt the program a lot of colleagues said it wouldn't work, that the 12 Step Program wasn't modifiable to therapy. It isn't true. The program works.

Perhaps the notion of a higher power is what so many professionals object to. To believe in God is not always fashionable within psychology. There is a long history of avoiding spiritual issues in counseling. Although I am a theist, higher power doesn't need to refer to God in the orthodox sense--the group, friends, a tree can be a higher power. It is simply the notion that there is a power greater than the individual and that power can give a person strength.

Fortunately, Hazelden (Steps 1-9, 1982) has published a series of pamphlets that adapt the AA 12 Step Program for people with eating problems. They have been

wonderful therapeutic tools although the series isn't yet complete; it goes only through Step 9 at present. The AA 12 Steps are as follows (rephrased for eating disorders):

1. We admitted we were powerless over our eating--that our lives have become unmanageable.

2. We came to believe that a Power greater than ourselves could restore us to sanity.

3. We made a decision to turn our will and our lives over to the care of that Higher Power (God) as we understand it.

4. We made a searching and fearless moral inventory of ourselves.

5. We admitted to our Higher Power, to ourselves and to another human being the exact nature of our wrong.

6. We have become entirely ready to have the Higher Power remove all these defects of character.

7. We humbly asked the Higher Power to remove our shortcomings.

8. We made a list of all persons we have harmed, and became willing to make amends to them all.

9. We made direct amends to such people wherever possible, except when to do so would injure them or others.

10. We continued to take personal inventory and when we were wrong promptly admitted it.

11. We sought through prayer and meditation to improve our conscious contact with the Higher Power praying only for knowledge of God's will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry these messages to other people suffering from eating disorders, and to practice these principles in all our affairs. (Alcoholics Anonymous, 1976, pp. 59-60)

There is an inherent danger to the AA program, and that is the external focus it fosters. A higher power does not have to exist outside an individual. Each person

needs to seek within her/himself for a source of personal power. I find the following story helpful in guiding people into their inner power. It is from Alan Watt's The Book: On the Taboo Against Knowing Who You Are (1972):

> There was never a time when the world began, because it goes round and round like a circle, and there is no place on a circle where it begins. Look at my watch, which tells the time; it goes round, and so the world repeats itself again and again. But just as the hour-hand of the watch goes up to twelve and down to six, so, too, there is day and night, waking and sleeping, living and dying, summer and winter. You can't have any one of these without the other, because you wouldn't be able to know what black is unless you had seen it side-by-side with white, or white unless side-by-side with black.
>
> In the same way, there are times when the world is, and times when it isn't, for if the world went on and on without rest for ever and ever, it would get horribly tired of itself. It comes and it goes. Now you see it; now you don't. So because it doesn't get tired of itself, it always comes back again after it disappears. It's like your breath; it goes in and out, and if you try to hold it in all the time you feel terrible. It's also like the game of hide-and-seek, because it's always fun to find new ways of hiding, and to seek for someone who doesn't always hide in the same place.
>
> God also likes to play hide-and-seek, but because there is nothing outside God, he has no one but himself to play with. But he gets over this difficulty by pretending that he is not himself. This is his way of hiding from himself. He pretends that he is you and I and all the people in the world, all the animals, all the plants, all the rocks, and all the stars. In this way he has strange and wonderful adventures, some of which are terrible and frightening. But these are just like bad dreams, for when he wakes up they will disappear.
>
> Now when God plays hide and pretends that he is you and I, he does it so well that it takes him a long time to remember where and how he hid himself. But that's the whole fun of it--just what he wanted to do. He doesn't want to find himself too quickly, for that would spoil the game. That is why it is so difficult for you and me to find out that we are God in disguise, pretending not to be himself. But when the game has gone on long enough, all of us will wake up, stop pretending, and remember that we are all one single Self--the God who is all that there is and who lives for ever and ever.
>
> Of course, you must remember that God isn't shaped like a person. People have skins and there is always something outside our skins. If there weren't, we wouldn't know the difference between what is inside and outside our bodies. But God has no skin and no shape because there isn't any outside to him. (With a sufficiently intelligent child, I illus-

trate this with a Mobius strip—a ring of paper tape twisted once in such a way that it has only one side and one edge.) The inside and the outside of God are the same. And though I have been talking about God as "he" and not "she," God isn't a man or a woman. I didn't say "it" because we usually say "it" for things that aren't alive.

God is the Self of the world, but you can't see God for the same reason that, without a mirror, you can't see your own eyes, and you certainly can't bite your own teeth or look inside your head. Your self is that cleverly hidden because it is God hiding.

You may ask why God sometime hides in the form of horrible people, or pretends to be people who suffer great disease and pain. Remember, first, that he isn't really doing this to anyone but himself. Remember, too, that in almost all the stories you enjoy there have to be bad people as well as good people, for the thrill of the tale is to find out how the good people will get the better of the bad. It's the same as when we play cards. At the beginning of the game we shuffle them all into a mess, which is like the bad things in the world, but the point of the game is to put the mess into good order, and the one who does it best is the winner. Then we shuffle the cards once more and play again, and so it goes with the world. (pp. 13-15)

"Deep down in every man, woman, and child is the fundamental idea of God," says the "Big Book" of AA. It is a great reality within each of us. It is my conviction that addictions arise out of spiritual bereavement. We see ourselves as lonely, inadequate, sick, bad, crazy, ugly, stupid, or fat. To stop these feelings, we turn to some substance, to some person, to something. We do so to cope. We do so to escape. And most addictions hook us because in the beginning, they work. They dull the fear, the loneliness, the pain. But we enter a vicious cycle, needing to use the addiction more. Because as we engage in more addictive behavior, it becomes less effective.

Your clients need to lose more weight, or they need to binge-purge more in order to display some semblance of normalcy. They are riding a roller coaster to nowhere except down. In the process of holding onto their dignity and their souls, they lose them. They need to recover their souls and their selves and the AA program provides a way that works. I am not an alcoholic, but I have my addictions and in all likelihood, so do you. I am benefitting from this program as much as my clients.

Read the section from the Hazelden pamphlet (Steps 1-9, 1982) on Step 3 called Giving Up the Game:

> It is a paradox that the harder we try to find freedom and pleasure through indulging our wants, the more enslaved and unhappy we become. The longer we work this program, the more firmly convinced we are that trying to go against God's will is at the root of our dissatisfaction and frustration. To be hooked on oneself is perhaps the worst addiction of all! Working through substance addiction-food abuse brings all of us into a confrontation with self-centeredness.
>
> Self-centeredness has driven us to the wall. We have tried to make ourselves happy by every conceivable means and find that the harder we try, the more miserable we become. One minute we think we will be happy if we can just be thin. The next minute, all we want is a pizza. A little while later, more money appears to be the solution to every problem. Then more love, more sex, more power. The list goes on and on.
>
> In order to make ourselves happy, we try to control not only our own lives but everyone else's too--especially the lives of those we love. We think we know best. We have the mistaken idea that power and control will give us freedom, when in fact the effort to hang on makes us fearful and anxious. (pp.12-13)

I suggest you order these pamphlets. The Hazelden telephone number is 1-800-328-9000. They also offer a daily meditation book called Food for Thought which my clients and I have found helpful and inspiring. If after examining these materials, you decide that they might work, try them. The steps lead to a great deal of discussion and insight. Our group designed their own homework assignments around each step. We work on a step each week. We spend a great deal of time on steps 1-4 and 8-9. Don't worry if you are on Step 10 and have a new arrival in group; the discussion always goes back to Step 1, to the admission that the addiction of choice is bigger than we are.

We also use massage in group. We find the personal touching important. Many of our clients are uptight about touching or being touched. We teach basic face and foot massage. If we are having a celebration and have more time, we teach back massage. We find that clients learn to feel comfortable with the touching. Most come to enjoy both giving and receiving the massage. We find that after a massage, they take more risks in group.

We also develop rituals. Rituals are important. They separate the ordinary from the extraordinary. They signal that something wonderful and powerful is taking place.

A graduation ritual is crucial. It signals an ending and a beginning. We require the graduating member to work up an after-care plan for herself. This should include what support systems she will utilize such as ANAD meetings, Overeaters Anonymous, ALANON (if they are close to someone who is chemically dependent) or AA (if it is appropriate). The plan also should include steps they can take if they experience a relapse, such as contact a group member or therapist. They are aware that if they need to return to group, they can. They are not alone. They need to state at least five life goals and five goals they want to attain within the next six months. These goals should be highly specific and should emphasize how to achieve them.

Our graduation ceremony is beautiful. It involves presenting the member with a guardian angel pin to remind her of her higher power and our caring. Each group member says good-bye, stressing what she has learned from the graduating member. It ends with a chant:

> Rainbow __Name__, Rainbow __Name__
> Go where you want to. Do what you want to.
> For Love is guiding you.

Then the graduating member goes to each member and physically says good-bye, without words. Graduations are times to celebrate and the happiness is highly infectious.

We use a variety of other rituals. Most involve candles, singing, and cleansing experiences. I refer you to Houston's Life Force: The Psychohistorical Recovery of the Self (1980) for some excellent ritual exercises.

Deciding when a client is ready to graduate is not difficult. The person announces her intent to the group usually about a month before she is to leave. Both the therapists and the group members confer together as to whether the person is ready. She usually is. Occasionally, someone rushes graduation. If other members have reservations, they say so. We require the graduating members to announce each week for three weeks the date of her graduation. The process is similar to announcing marriage banns. On each occasion, the clients are told they can change

their minds. We do this to reinforce the nature of the choice and that it is not written in stone.

Although people seldom rush graduation, many more delay it. Be wary of clients who become dependent on the group. You may have to confront them on their dependency. Do so gently, but firmly. In all cases, discuss the after-care plan thoroughly with each graduating member. Seek suggestions from the whole group.

As is probably evident, the therapy we do in group represents an eclectic approach. We use rational-emotional techniques, Gestalt and process techniques, spiritual counseling, neurolinguistic programming, behavior modification, desensitization and confrontation. We do not believe that any one approach is best. They all work. What is important is that you use a wide array of techniques. Your bag of tricks needs to be large enough to meet the demands of the disorders. If you can, try to utilize a therapist team where the backgrounds and biases are different. Differences of style and technique are highly successful. They result in meeting the needs of more clients, broadening the clinical perspective, making therapist behavior more unpredictable and hence less open to manipulation, and enriching the therapeutic experience.

Experiment. Observe. Keep good data. Remain open. And enjoy. We do.

Chapter VII
FROM HERE, WHERE?

I don't possess a crystal ball and examining future trends is not my expertise. But as a practitioner and researcher, I can share with you what I hope will happen.

First, drug research will continue to advance. Future pharmacological studies will focus on eliminating the hormonal imbalance that is often found in both eating disorders. Research will continue into the use of anti-depressants and other mood-altering drugs. Pharmacologists will attempt to develop drugs which both stimulate and decrease appetite without harmful side-effects.

Second, researchers will try to unravel whether there is a physiological base to the eating disorders. Even if this is not found, they will examine the effects of these disorders on the body's functioning, especially within the hormonal and nervous systems. Much of this research will probably be focused on obesity rather than anorexia or bulimia.

We will see the spread of eating disorder clinics offering intensive outpatient and inpatient care. You will likely see such programs in mid-sized cities. Most will be modeled after the currently existing chemical dependency programs. Hopefully, future therapists and counselors from all the helping professions will receive graduate training in the area.

The relationship between chemical dependency and eating disorders needs to be examined. Right now, many major chemical dependency treatment programs, such as Hazelden, refer all active eating disordered clients to treatment programs for that disorder first. Dr. Eckert at the University of Minnesota program, however, suggests that chemical dependency needs to be addressed first ("Eating Disorders," 1983). This is the classic case of not knowing who should take responsibility. It is my contention that chemical dependency needs immediate intervention. That intervention provides the client with a more easily understood model of addiction. The client can then apply that model to her/his food issues. The best of all possible worlds is to deal with both disorders simultaneously. This can happen when providers focus on the similarities between the dependencies, rather than on their differences.

The whole area of incest and rape as it relates to later addiction needs more investigation. Incest is far more common in the population than anyone has realized. I wonder how much of all addictive behavior to substances, people, and things is related to this national trauma. Clinicians and researchers need to address more deeply the sexual issues surrounding anorexia and bulimia.

Premenstrual syndrome needs thorough investigation. Many feminists find the disorder uncomfortable because it seems to give credence to some discriminatory, societal notions. These include the ideas that women are unstable, unreliable, or unpredictable because they menstruate. Yet, I fear that people who hold these notions will use PMS to assert their contentions anyway. I can't change what some misguided individuals might choose to do. Increasingly, there seems to be a crucial relationship between PMS symptoms and urges to binge and consume alcohol. We need more thorough research. We have to change our state of ignorance.

We will see the development of more adjunctive support systems. Overeaters Anonymous will become more accepting of bulimics. More Bulimics Anonymous groups will be formed. Even small towns may host ANAD and other support groups.

The most important focus needs to turn from healing the disorders to preventing them. I don't believe the eating disorders are going to leave us quickly, short of famine or a change in our society's view of being overweight. We need to address the entire issue of food abuse in our schools. Starting in elementary school, children need to learn more about nutrition than the five basic food groups. Junior-high age children need to learn about how to cope with puberty, not just what it is. High school students need help in learning how to validate themselves. They need information about anorexia and bulimia. Food abuse needs as much attention as we currently give to preventing drug abuse. These young people don't need propaganda; they need information about which they can make choices. Even if they choose to become bulimic or anorexic, they need to be aware that it is a choice.

Families need help. Future treatment approaches must focus on the individual as she exists within a family. The family members are suffering as much as, and perhaps more than the afflicted member.

Finally, I believe that anorexia and bulimia can help break down the traditional barriers between the helping professions. Physicians can no longer afford not to talk to psychologists, counselors, or social workers, and these three need to learn to talk

and share with each other without malice and feelings of territoriality. All of us need the help of dieticians and, as practitioners, need to have more knowledge of nutrition.

These disorders may be a blessing in disguise. Perhaps they will bring about a true team approach to treatment, a team in which every member is important, every member is of value, and every member cares about not only the client but each other.

As the author Richard Bach says, "Every problem comes bearing a gift." Perhaps the gift of anorexia and bulimia is the development of a sense of community among the helping professions.

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Appendix I

BASIC NUTRITION USING THE EXCHANGE SYSTEM

Basic nutrition is important for everyone's health. Whether undergoing weight loss or weight gain, or maintaining present weight, an individual must consume the correct balance of all nutrients in order to maintain a healthy body. The following plan, the exchange system, is a controlled way to achieve good nutrition. It divides the foods you eat into six groups according to their content of the three energy producing nutrients: carbohydrate, protein, and fat. It also takes into consideration their vitamin and mineral content so that by following your prescribed plan, you will automatically receive an adequate kilocalorie level and the proper balance of nutrients.

How Your Meal Plan Works

Each participant, depending on nutritional needs and personal eating habits and preferences, will be given a food prescription by the nutritionist. To use the exchange system and your prescription, follow these instructions:

When your meal plan calls for one exchange from a list, select one item from that list and use only the amount listed. If it calls for two exchanges from the same list, use two times the amount of one item or select two different items. Three meat exchanges in the same meal is three ounces of meat, as one meat exchange is one ounce. Include one vitamin C source daily and one vitamin A source every two days. The nutritionist will explain sources of these.

Your meal prescription is:

B	AM	L	PM	D	HS
___skim milk		___skim milk		___skim milk	
___fruit		___fruit		___fruit	
___bread/starch		___vegetables		___vegetables	
___meat		___bread/starch		___bread/starch	
___fat		___meat		___meat	
		___fat		___fat	

Basic Rules

1. Cooked foods should be prepared by baking, broiling, steaming, boiling. Do not add fat (oil, butter, margarine) unless you count it in your fat exchanges. Use of oils and margarines is recommended in higher level prescriptions where weight gain is desirable. In lower kilocalorie prescriptions, most users prefer to save their fat exchanges for medium or high-fat meats, salad dressings, or margarine and butter.
2. Measure--know your serving sizes. There is a lot of kilocalorie difference between one and two teaspoons of margarine. The use of a gram scale is beneficial for weighing meats. Measuring cups and spoons should be available. Those eating away from home should make estimates of portion sizes as accurate as possible.
3. Eat three or more meals a day as prescribed. If you prefer smaller amounts of food, divide your prescription into six meals. If you prefer fewer, larger meals, your food should be consumed in at least three meals. Do not go below three meals.
4. Stick to your plan. If you go off your plan one day or meal, GET BACK ON YOUR PLAN--you have not failed, only taken a temporary detour. You can control your habits.
5. Seek the support of others in your support group. If you are not in a group, bring your questions to our next appointment with the nutritionist. Write down questions as they occur.

6. If you wish, you may purchase cookbooks which use the exchange system. Most of these are written for the diabetic but give excellent nutritious recipes for anyone using the exchange system.
7. Keep food records. Writing down what you eat helps you evaluate your own progress.
8. If you prepare your own meals, plan each day's menu prior to each day and stick to it. You may want to plan out menus for an entire week so that you can grocery shop less often. If large supplies of food tempt you to binge, keep only minimal amounts on hand. If you eat in a residence hall dining center, check the menu each morning at breakfast and plan your menu at that time. This will help you stay within your exchange prescription.
9. Do not consume excess amounts of sugarless gum or diet pop. The sweeteners in sugarless gum can cause gas, bloating, and possibly diarrhea. Some diet pops high in sodium will also contribute to bloating. Usually two cans of pop a day and one pack of gum should be a maximum if you experience these problems.
10. Do not weigh every day. Your body weight will vary from day to day with the type and quantity of food you consume, the amount of water you are retaining, the salt content of your diet, and the weather. Weighing once a week is the very best. Preferably weigh with either the nutritionist or the psychologist.
11. Your prescription will at first contain primarily your "safe" foods. As you feel control strengthening, you will be advised to start including your binge foods. Those who have not been binging will be advised to start out their prescription with nutrient dense foods in order to assure proper nutrient intake at the prescribed kilocalorie level.
12. If you have been consuming very low quantities of food or have been purging by vomiting or using laxatives, you could possibly experience the following symptoms. They are natural responses of your body and will pass as you continue your food plan.

Constipation:

Include whole grain breads and cereals and fresh fruits and vegetables in your plan to help overcome this problem. Your intestinal tract has slowed down because of your abuse and needs time to adapt to new levels of food intake.

Bloating:

This will subside shortly if you stick to your plan. Go easy on the salt and salty foods for a while.

Feeling fat:

Your body has been conserving every kilocalorie and you may initially gain weight that you may not consider desirable. By checking in with the nutritionist, you can adjust your prescription to fit the desired weight you wish to achieve. After time your body will adapt to normal kilocalorie levels.

Weight fluctuations:

Your weight will fluctuate. You could gain two pounds one week and lose three the next. Your natural body cycles and your water balance can cause this.

Gas or flatulence:

This can be caused by sugarless gums or bacterial fermentation (a natural occurrence) in the intestine. Until natural gastrointestinal bacteria stabilize, sticking to the food plan and staying away from gas-producing foods may help.

Appendix II

EATING DISORDERS CLINICS AND OTHER PROGRAMS

If you live near any of the following major centers, ask about their treatment programs. If they don't suit you, or if their waiting lists are long, ask for referrals. You can also contact your local hospital for referrals.

East Coast

David B. Herzog, M.D., Director
Eating Disorders Unit
Massachusetts General Hospital
Fruit Street
Boston, MA 02114

Katherine A. Halmi, M.D., Director
Eating Disorders Program
New York Hospital-Cornell Medical Center
Westchester Division
21 Bloomingdale Road
White Plains, NY 10605

B. Timothy Walsh, M.D., Director
Eating Disorders Research and Treatment Program
New York State Psychiatric Institute
Columbia Presbyterian Medical Center
722 West 168th Street
New York, NY 10032

Judith Brisman, Ph.D. (or Ellen Schor, Ph.D.)
Center for Bulimia and Related Disorders
31 West 10th Street
New York, NY 10011

William Davis, Ph.D.
Center for the Study of Anorexia and Bulimia
1 West 91st Street
New York, NY 10024

Arnold E. Andersen, M.D., Director
Eating and Weight Disorders Clinic
Henry Phipps Psychiatric Clinic
Johns Hopkins Hospital
600 North Wolfe Street
Baltimore, MD 21205

Midwest

Craig Johnson, Ph.D., Director
Anorexia Nervosa Project
Michael Reese Medical Center
Psychosomatic and Psychiatric Institute
2959 South Cottage Grove
Chicago, Il. 60616

Richard L. Pyle, M.D., Director
Behavioral Health Clinic
University of Minnesota
Box 301, Mayo Memorial Building
420 Delaware Street, SE
Minneapolis, MN 55455

West Coast

Joel Yager, M.D., Medical Director
Eating Disorders Clinic
Neuropsychiatric Institute
Center for the Health Sciences
University of California at Los Angeles
760 Westwood Plaza
Los Angeles, CA 90024

Barton J. Blinder, M.D., Director
Eating Disorders Program
Department of Psychiatry and Human Behavior
College of Medicine
University of California at Irvine
Irvine, CA 92717

Appendix III
EATING DISORDERS ASSOCIATIONS

National Association of Anorexia Nervosa and Associated Disc ers, Inc.
Box 271
Highland Park, IL 60035
(312) 831-3438
(Individuals requesting information should send a self-addressed envelope with $.37 postage; organizations should send $1.00 to cover postage and handling.)

American Anorexia Nervosa Association, Inc.
133 Cedar Lane
Teaneck, NJ 07666
(201) 836-1800 (10 a.m. to 2 p.m. EST)

American Anorexia Nervosa Association of Philadelphia, Inc.
Philadelphia Child Guidance Clinic
Philadelphia, PA 19104
(215) 387-1919

National Anorexic Aid Society
Box 29461
Columbus, OH 43229

Anorexia Nervosa and Related Eating Disorders, Inc.
P.O. Box 5102
Eugene, OR 97405

Anorexia Nervosa Aid Society of Massachusetts, Inc.
Box 213
Lincoln Center, MA 01773

American Anorexia Nervosa Association of Atlanta
3533 Kingsboro Road, NE
Atlanta, GA 30319
(404) 233-7058